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ABSTRACT

This set of materials is designed to provide helping professionals with sufficient understanding of third-party payment systems so they are able to determine the feasibility of obtaining reimbursement for service, identify potential third-party payers, assess implications of introducing a third-party payments system, and develop a plan for obtaining third-party reimbursement. The materials address the following areas of concern: background, key issues, third-party payers, confidentiality, administrative considerations, financial management, and project ISSA planning. Examples of workshop packet materials, flip charts, equipment needs, and references are included with the trainer's manual. (Author/HLM)

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ED177415

THIRD PARTY PAYMENTS

Alternative Funding Sources for Drug Abuse Treatment Programs

TRAINER'S MANUAL
and
TRAINEE'S HANDBOOK

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

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COURSE OVERVIEW

PURPOSE

This course aims to give participants sufficient understanding of the third party payments system to enable them to -

- determine if it is feasible to obtain reimbursement for services provided to clients
- identify potential third party payers
- assess the implications of introducing a third party payments system; and
- develop a plan for obtaining third party reimbursement

AUDIENCE

The trainees should be administrators of drug abuse treatment projects and Single State Agency personnel.

NUMBER OF TRAINEES

The suggested number of trainees in between twenty and thirty.

CONTENT

Topics to be covered

- BACKGROUND: Describes the third party reimbursement system, explains how it works, and discusses reasons for seeking third party payments.
- HEALTH SERVICE FUNDING REGULATIONS: Emphasizes the value of financial planning for effective treatment program operation. Reviews the Health Services Funding Regulations in this regard with particular attention to HSF's requirements for a General Plan and Financial Plan.
- KEY ISSUES: Identifies, defines, and reviews the significance and implications of eligibility requirements for client, provider, and service as these relate to third party payments.
- THIRD PARTY PAYERS: Identifies and describes potential third party payers and discusses the client, provider, and service eligibility criteria of each. Each payer is assessed in terms of its relevance to drug abuse treatment programs.
- CONFIDENTIALITY: Summarizes federal confidentiality regulations pertaining to alcohol and drug abuse patient records. Cites some specific requirements; discusses program and client implications.
- ADMINISTRATIVE CONSIDERATIONS: Reviews the major administrative implications of introducing a third party payments system.
- FINANCIAL MANAGEMENT: Reviews the financial considerations necessary for utilization of a third party payments system.
- PROJECT/SSA PLANNING: Gives participants an opportunity to identify and list in priority order, specific actions needed to implement a third party system in their program (or state).

METHODOLOGY

The course relies heavily on instructor presentations but participant involvement is encouraged by the use of small-group workshops, small- and large-group discussions, and individualized study.

Because the course is designed to be presented to participants from many states, use of state-specific material is minimal. If the course is given to participants from only a few states, state-specific information on Medicaid and title XX should be included. This is best accomplished by using representatives of the states' Medicaid and title XX agencies to present the portions of Session 4 dealing with those payers.

The course presentation closely parallels the material in the Trainee Handbook: participants should be encouraged to read it along with the course.

MATERIALS

- Flip charts (F-1 - F-10)
- Handouts
  - H-1: Sample Daily Schedule
  - H-2: HSF Regulations
  - H-3: Client Third Party Eligibility Checklist
  - H-4: Federal Register (7/1/75)
- Workshop packets
  - W-1: Medicaid - Title XX Workshop
  - W-2: Third Party Payers Workshop
  - W-3: Project Planning Workshop
  - W-4: SSA Planning Workshop
- Trainee Handbook
- Notepads
  Pencils and pens

EQUIPMENT

- Chalkboard and/or blank flip charts/1 per meeting room
- Flip chart easels/1 per meeting room
- Felt tip markers

PERSONNEL REQUIREMENTS

- Trainer
- Expert consultant: third party payments
- Expert consultant: financial management of health care center
- Facilitators (2-4 recommended)

FACILITIES

- Large-group meeting room
- Small-group meeting rooms (4-5)
- Small-group work areas (5-7)

TIME REQUIREMENT

Three days (8-10 hours per day)

PREFACE

This manual has been prepared by the National Drug Abuse Center for Training and Resource Development (NDAC) for use within the National Training System of the National Institute on Drug Abuse.

The highly technical nature of the Third Party Payments (TPP) Course requires that the instructor become familiar with much of the technical material contained in the Trainee Handbook, which is the basic text and reference document for the course. Additionally, effective presentation of the course material requires prior participation in the TPP training of trainers course conducted by NDAC. No instructor should attempt to conduct this course without the aforementioned preparation. Previous training experience and familiarity with drug abuse treatment programs are desirable, but not essential, trainer characteristics.

In examining the Health Services Funding Regulations in Session 2, the trainer should note that the regulations encourage programs to consider two things with regard to implementing a third party payments system: first, what programmatic changes would be necessary, and, second, which payers could be utilized. It is recommended that the trainer stress the probable outcome of inquires to insurors: in becoming aware of this potential market, insurors may begin to examine their policies and the payment criteria necessary to take advantage of this market.

It is strongly recommended that an individual who is knowledgeable about the third party payments system be used as a technical consultant during the presentation of the course. This consultant would be helpful in responding to technical questions posed by trainees. Additionally, it is recommended that Session 7 (Financial Management) be delivered by someone who is familiar with the process of determining the cost of services and preparing a fee schedule.

A sample daily schedule has been prepared for utilization in course delivery. It assumes that the course will be presented on three consecutive days beginning at 9:00 a.m. You may wish to adapt this to fit the training needs of your group, changing the times or the number of days needed for presentation. The course can be delivered in nightly sessions or during weekends; you will need to adjust the schedule to fit your requirements.

The remainder of the manual contains presentation materials for each of the eight sessions. The order of these sessions closely parallels the order of material presented in the Trainee Handbook. First there are the objectives of each session. Following these is a general list of personnel, logistic, and material requirements. The activities sheets for each session contain an outline of the content to be covered, suggest the time necessary for each activity, and provide references and materials that will be needed (e.g., flip charts, handouts, etc.)

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EVALUATION

The formative evaluation of this course was conducted in two stages, each of which contributed to the text and training design as it now appears. The first stage of evaluation consisted of an ongoing internal review of the course material and training design through its developmental phases. The second review phase consisted of an external review by a team comprising experts outside of NDAC and known for their expertise in third party reimbursement and instructional technology. The specific composition of the external review team is noted in the prefaces to these manuals. Each of these review processes resulted in some revisions to the course before field trial.

The final stage of revision was a field trial of the course on a sample of trainees for whom the course in intended and under conditions that were characteristic of the training population at large. Two field trials were conducted--one in Chicago, Illinois, and the second in Oklahoma City, Oklahoma. The field trials were a cooperative venture between NDAC and the former Regional Training Centers located in Chicago and Norman, Oklahoma. Trainees were recruited by NDAC through field test announcements sent to all NIDA supported drug abuse treatment programs. All respondents who indicated a desire to participate in the field tests at the specified locations were selected for participation. Approximately 10 percent of the respondents indicating a desire to participate in the field test were "no shows."

A total of 16 individuals participated as trainees in the Chicago field test and 12 in Oklahoma City.

The Chicago field test was conducted by the NDAC course developer responsible for the course and head of the Materials Development Section of NDAC. Trainers from the Chicago and Norman Regional Training Centers served as facilitators. The Norman field test was conducted by two members of that RTC's training staff.

All RTC personnel involved in the field testing received one week of formal instruction prior to the field trial deliveries. Each field trial was conducted in the same manner using the trainer instructions specified in the Trainer's Manual.

Parallel forms of pre- and posttests, consisting of 30 multiple choice and true/false items were used to measure learning gain. The tests were related specifically to the training objectives and were designed to measure recall and interpretation of material presented in the course. In addition to the objective test, subjective measures were used to obtain the trainees' opinion on such factors as the usefulness, clarity, and relevance of each training session. A Likert-type scale of 1 through 5 (where "1" was poor and "5" excellent) was used for this purpose.

RESULTS

The overall learning gain obtained on the first field trial (Chicago) was 18 percent;* the overall learning gain obtained on the second field trial (Norman) was 40 percent.**

The higher learning gain obtained on the second field trail is believed to be due to two factors: (1) An analysis was made of the test items most frequently missed during the first field trial and the course modified to place greater emphasis on that portion of the instructional material related to the objectives tested by these items; and (2) the trainees participating in the Norman field test were generally less well informed about third party payments, and thus closer to the intended trainee population, than those in Chicago.

The results of the subjective trainee opinion assessment for field trials 1 and 2 are shown in Table 1 and Table 2 respectively. The demographic characteristics of the trainees is shown in Table 3.

---

* Significant at the .05 level of confidence.
**Significant at the .01 level of confidence.

Table 1

Results (Trainee Opinion Assessment - Field Trial No. 1)

Training Session	Mean Score Per Session	Mean Score Per Rating Category						
		a	b	c	d	e	f	g
Health Services Funding Regulations	4.3	4.0	4.1	4.5	4.9	4.2	4.1	4.0
Key Issues	4.0	4.0	3.9	4.3	4.2	4.2	3.7	4.0
Third Party Payers	4.0	3.8	3.9	4.1	4.1	3.9	4.3	4.1
Confidentiality	4.5	4.4	4.5	4.6	4.7	4.5	4.5	4.5
Management and Staff Issues	4.0	4.0	4.1	4.3	4.1	4.0	4.1	3.7
Fee Schedules	4.0	3.9	4.4	4.1	4.1	3.9	4.2	3.8
Project/SSA Planning	4.5	4.4	4.4	4.6	4.6	4.5	4.5	4.6
Mean	4.2	4.1	4.2	4.4	4.4	4.2	4.2	4.1

Note: The participants were asked to evaluate each training session according to a number of variables (items a-g below) using a one to five rating scale.

Score Interpretation: 1 = poor; 5 = excellent

Rating Categories:

a. Achievement of its objectives
b. Usefulness of information presented
c. Usefulness/relevance to your work situation
d. Appropriateness of level of language used
e. Logic and sequence of training activities
f. Interest level of training activities
g. Clarity with which training activities were presented

Table 2

Results (Trainee Opinion Assessment -- Field Trial No. 2)

TRAINING SESSION	MEAN SCORE PER SESSION	MEAN SCORE PER RATING CATEGORY*						
		a	b	c	d	e	f	g
Health Services Funding Regulations	3.9	3.8	3.9	3.8	3.9	3.8	4.0	3.9
Key Issues	4.3	4.2	4.1	4.0	4.4	4.6	4.2	4.4
Third Party Payers	4.2	4.1	4.3	4.2	4.5	4.3	4.3	3.8
Confidentiality	4.6	4.5	4.6	4.5	4.5	4.6	4.6	4.7
Management and Staff Issues	4.6	4.5	4.6	4.7	4.6	4.3	4.6	4.7
Fee Schedules	4.3	4.3	4.1	4.0	4.3	4.5	4.3	4.3
Project/SSA Planning	4.4	4.3	4.2	4.5	4.4	4.5	4.5	4.4
MEAN	4.3	4.2	4.3	4.2	4.4	4.4	4.4	4.3

Note: The participants were asked to evaluate each training session according to a number of variables (items a-g below) using a one to five rating scale.

Score Interpretation: 1 = poor; 5 = excellent

Rating Categories:

a. Achievement of its objectives
b. Usefulness of information presented
c. Usefulness/relevance to your work situation
d. Appropriateness of level of language used
e. Logic and sequence of training activities
f. Interest level of training activities
g. Clarity with which training activities were presented

SAMPLE DAILY SCHEDULE

DAY 1

9:00 - 9:30	Pretest
9:30 - 11:00	Introduction
11:00 - 11:15	Break
11:15 - 11:45	Health Service Funding Regulations
11:45 - 12:45	Lunch
12:45 - 1:50	Key Issues
1:50 - 2:00	Break
2:00 - 3:05	Key Issues (Cont'd.)
3:05 - 3:20	Break
3:20 - 5:20	Third Party Payers - Introduction - Medicaid - Title XX

SAMPLE DAILY SCHEDULE

DAY 2 (Option A)*

9:00 - 10:30	Third Party Payers (Cont'd.) - Medicare - Vocational Rehabilitation - CHAMPUS - Food Stamps - Private Payers - Health Maintenance Organizations - National Health Insurance
10:30 - 10:45	Break
10:45 - 11:35	Third Party Payers (Cont'd.) - Workshop and Group Discussion
11:35 - 1:00	Lunch
1:00 - 2:20	Confidentiality
2:20 - 2:35	Break
2:35 - 3:45	Administrative Considerations: - Management Issues
3:45 - 4:00	Break
4:00 - 5:10	Administrative Considerations: -Staff Issues Option A - Workshop
or	
4:00 - 4:30	Administrative Considerations (Cont'd.) - Staff Issues Option B - Discussion

* Includes a 15 minute lecture on private payers.

SAMPLE DAILY SCHEDULE

DAY 2 (Option B)*

9:00 - 10:30	Third Party Payers (Cont'd.) - Medicare - Vocational Rehabilitation - CHAMPUS - Food Stamps - Private Payers
10:30 - 10:40	Break
10:40 - 11:25	Third Party Payers (Cont'd.) - Discussion of Private Payers - Health Maintenance Organizations - National Health Insurance
11:25 - 12:15	Third Party Payers (Cont'd.) - Workshop and Group Discussion
12:15 - 1:30	Lunch
1:30 - 2:40	Confidentiality
2:40 - 2:55	Break
2:55 - 4:05	Administrative Considerations - Management Issues
4:05 - 4:20	Break
4:20 - 5:30	Administrative Considerations (Cont'd.) - Staff Issues
or	
4:20 - 4:50	Administrative Considerations (Cont'd.) - Staff Issues (Optional Session)

* Includes a one-hour workshop session on private payers.

SAMPLE DAILY SCHEDULE

DAY 3

9:00 - 9:35	Administrative Considerations (Cont'd.) - Record Keeping - Wrap-up
9:35 - 9:45	Break
9:45 - 11:35	Financial Management (Option A: Lecture presentation)
or	
9:45 - 11:15	Financial Management (Option B: Discussion)
11:15 or 11:35 - 1:30	Lunch
1:30 - 3:00	Program/SSA Planning
3:00 - 3:15	Break
3:15 - 3:45	Posttest

KEY

Symbols

SG	Small Group
LG	Large Group
M-L	Mini-Lecture
D	Discussion
I	Individual

Colors

Tan	Trainee's Handbook
Tan	Appendix 1 Workshop Packets
Yellow	Appendix 2 Test Forms A & B
Brown	Appendix 3 Additional References and Resources

SESSION I

BACKGROUND & INTRODUCTION

SESSION 1

LEARNING OBJECTIVES

The purpose of this session is to establish an appropriate learning environment by outlining the course content, explaining the course structure and providing a general explanation of the third party payments system.

At the end of this session participants will be able to–

- define "third party payments";
- identify the three parties in a third party payments system;
- identify at least five implications for a drug abuse treatment program seeking third party payments;
- identify the two methods by which service providers are reimbursed in a third party payments system;
- identify the two types of third party payers.

SESSION: 1

SESSION REQUIREMENTS

PERSONNEL	Trainer
TIME	2 hours
EQUIPMENT	Chalkboard Flip chart easel
MATERIALS	Pretests Prepared flip charts (F-1, F-2, F-3) Note pad and pencils for each participant Handout H-1 (Sample Daily Schedule)
FACILITY	Large-group meeting room

Session 1: INTRODUCTION

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
30 min. LG	Pretest	PRETEST ● Administer pretest.
15 min. LG M-L/D	Chalkboard	INTRODUCTION ● Introduce each trainer/facilitator. ● Explain purpose of the course: *This course is intended to provide information that will help you (a) assess feasibility of obtaining Third Party Payments and (b) determine required actions for obtaining TPPs.* (Write on chalkboard.) ● Note that the course provides guidelines but cannot specify each step required to obtain TPPs.
	Handout (H-1) (Daily Schedule) Flip Chart (F-1)	● Outline the course content and daily schedule. *(Write on newsprint and see sample flip charts at end of activities sheets.)* ● Discuss the logistics *(when, where, any rules)*. ● Answer any questions.
15 min.		WARM-UP EXERCISE ● Explain purpose of the exercise: *This exercise should help you become acquainted with each other.* ● Use whatever technique you have found to be useful to help trainees identify names and/or other associations *(e.g., treatment modality represented)*.
45 min. LG M-L/D	p. 17	INTRODUCTION TO THIRD PARTY PAYMENTS ● Define third party payments: *A third party payment is a payment for a service provided to an individual by an individual or organization that neither receives nor provides the service.*

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
		INTRODUCTION TO THIRD PARTY PAYMENTS (CONT'D)
	p. 18	● Explain key terms: client *(service recipient)* provider *(service provider)* third party *(e.g., John Hancock Co., Medicaid).* service *(assistance given to client)*
	Flip Charts F-2, F-3	● Explain interrelationships among client, provider, and payer. *(See sample flip charts)*
	Figure 1.1 Figure 1.2	● Distinguish types of third party payers: *Public reimbursers* Federal/state programs supporting services to various categories of individuals, i.e., Medicaid, Medicare, title XX, Vocational Rehabilitation, etc. *Private reimbursers* Profit making *(e.g., Aetna, John Hancock)* Nonprofit *(e.g., Blue Cross/Blue Shield)*
		● Discuss the fact that public reimbursers presently provide most payments for addicts.
		● Note that to obtain TPPs, the eligibility of the client, provider, and service must be established.
		● Mention that each type of eligibility will be discussed in greater detail in a later session.
		● Note some of the difficulties existent within the third party payment's system, for example: Federal regulations regarding eligibility vary considerably between programs. State criteria vary between states and within each program *(i.e., no two states have the same set of criteria for Medicaid).*

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
		INTRODUCTION TO THIRD PARTY PAYMENTS (CONT'D)
	pp. 23-26	● List some of the benefits offered a drug treatment program by third party payments, for example: Sources for required "match" funds Reduction of dependency on a single funding source Expansion or improvement of the program Preparation for National Health Insurance Improved program credibility
15 min. LG D		DISCUSSION ● Conduct discussion about implications for treatment programs of TPPs. *The purpose of this discussion is to help you identify important issues relating to TPPs (e.g., charging clients, staff requirements, confidentiality, record keeping, etc.)* ● Identify those issues that will be discussed in the course. ● Answer any questions.

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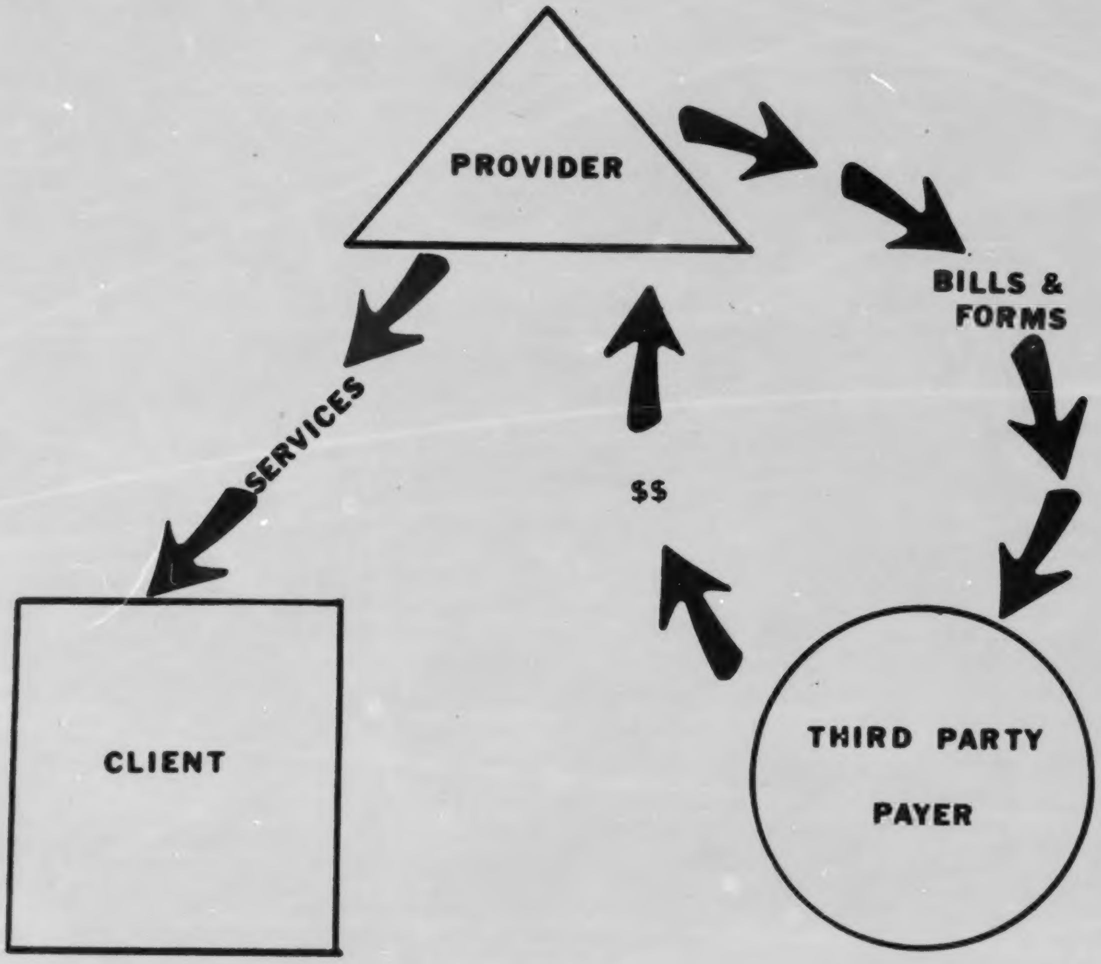
COURSE CONTENT

- INTRODUCTION
- HSF REGULATIONS
- KEY ISSUES
- THIRD PARTY PAYERS
- CONFIDENTIALITY
- MANAGEMENT & STAFF ISSUES
- FINANCIAL MANAGEMENT
- PROJECT/SSA PLANNING

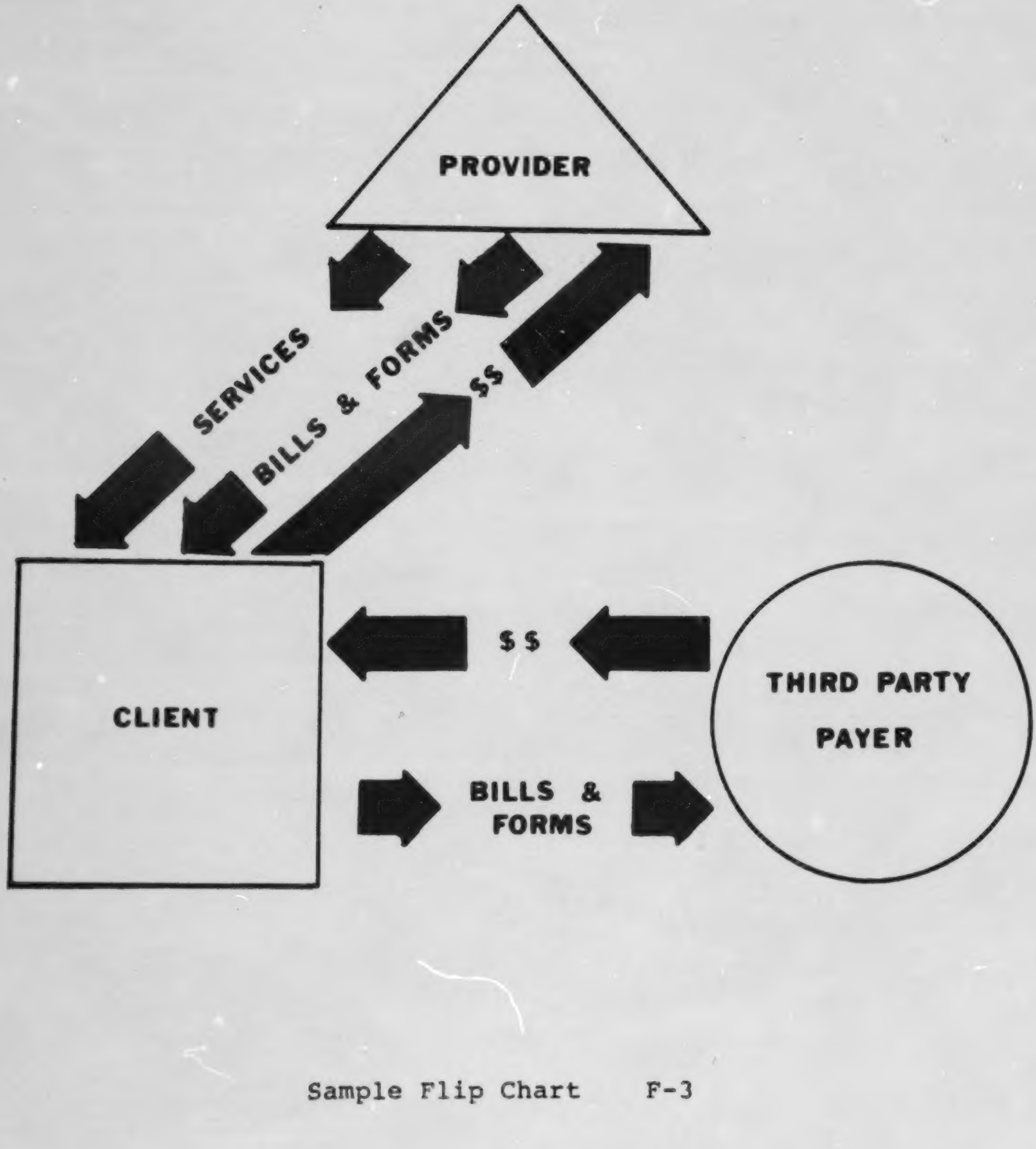
Sample Flip Chart F-1

DIRECT REIMBURSEMENT OF SERVICE PROVIDER


PROVIDER
BILLS & FORMS
SERVICES
$$
CLIENT
THIRD PARTY PAYER

Sample Flip Chart F-2

INDIRECT REIMBURSEMENT
OF SERVICE PROVIDER


PROVIDER
SERVICES
BILLS & FORMS
$$
CLIENT
$$
THIRD PARTY PAYER
BILLS & FORMS

Sample Flip Chart F-3

SECTION 1

BACKGROUND & INTRODUCTION

At the same time that health care costs are rising, federal funding is becoming more constrained. Many types of providers in the health care delivery system are therefore devoting increased attention to developing sources of support that will assure continued adequate funding for their programs.

Private health insurance has assisted individuals in meeting the costs of many traditional types of health care. The advent of such programs as Medicare, Medicaid, and more recently title XX (social services funding), has made public financing an increasingly more important source of funding for health and social service programs. Currently, considerable attention is being given to the development of some form of national health insurance as a means of providing health care benefits to most of the people in this country.

Thus, at the present time, and for the foreseeable future, these and other sources of "third-party" funding will constitute an essential element in the system of financing health care in the United States.

WHAT ARE THIRD PARTY PAYMENTS?

Medical treatment normally involves two parties: a patient (or client) who receives some type of treatment or service and an individual or organization that provides that treatment or service.

The provider may be a physician, counselor, hospital, clinic, residential treatment center, or some other source. The provider may be reimbursed directly by the client or indirectly by an insurance company (private third party) or public agency (public third party). The last two are referred to as "third parties" because they are not directly involved in the service encounter. For purposes of this course, then, "third party payments" is defined as: payment for service provided to an individual by one who is neither the receiver nor provider of the service.

HOW THIRD PARTY REIMBURSEMENT WORKS

The basic characteristic of third party payments is that services are paid for (either in full or in part) by someone (or some entity) who is neither the individual receiving the service nor the person or organization providing the service.

There are two basic ways in which a provider is reimbursed by the third party. In the first, the provider renders service or treatment to a client who is eligible* to receive payment for services from a third party payer. The provider sends bills for the service, together with any necessary claim forms, to the third party payer. The payer then reviews the claim, and if it is in order, payment is made directly to the provider. This method is sometimes called the assignment method, as the client must formally assign his right to the payment for the claim to the provider. This method is typical of Medicare, Medicaid, and Blue Cross/ Blue Shield (see Figure 1.1). In the second method, the provider sends a bill to an eligible client who pays it and then submits a claim to the third party. If the claim is approved, the third party then reimburses the client (see Figure 1.2).

Whichever method is used, some type of claim form must be submitted along with the bill for services. The claim form provides the third party with information needed to determine whether the claim should be paid. This determination is generally based on three factors: eligibility of the client, eligibility of the provider, and eligibility of the service rendered. The specific criteria on which these eligibility determinations are made are noted in the insurance policy (in the case of private payers) or in federal and state regulations (in the case of public third party payers).

Client Eligibility

Client eligibility refers to the determination of whether the individual receiving services is entitled to benefits from a third party. In the case of private third parties, an eligible client is one who has either purchased an insurance policy for himself and/or his family (individual policy) or has had it purchased for him by his employer, union, fraternal organization or other source (group policy). In the case of public third party payers, an eligible client is generally one who is entitled to benefits provided by one of the programs established through the Social Security Act (i.e., Medicaid, Medicare, title XX). Individual eligibility in the case of public payers is generally related to low income and either physical condition (e.g., age, blindness, inability to work) or welfare status (e.g., AFDC recipients).

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*An "eligible" client is one who meets the client criteria established by the payer and has formally established a relationship with that payer.

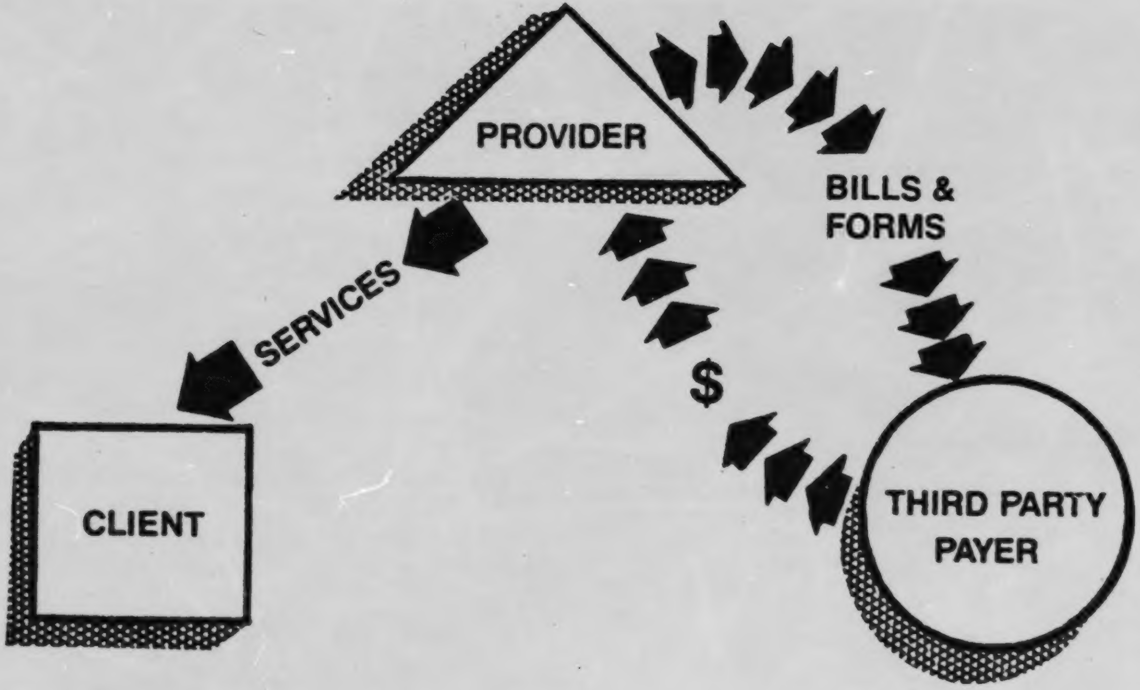
PROVIDER
BILLS & FORMS
SERVICES
$
CLIENT
THIRD PARTY PAYER

FIGURE 1.1. Direct Reimbursement of Service Provider

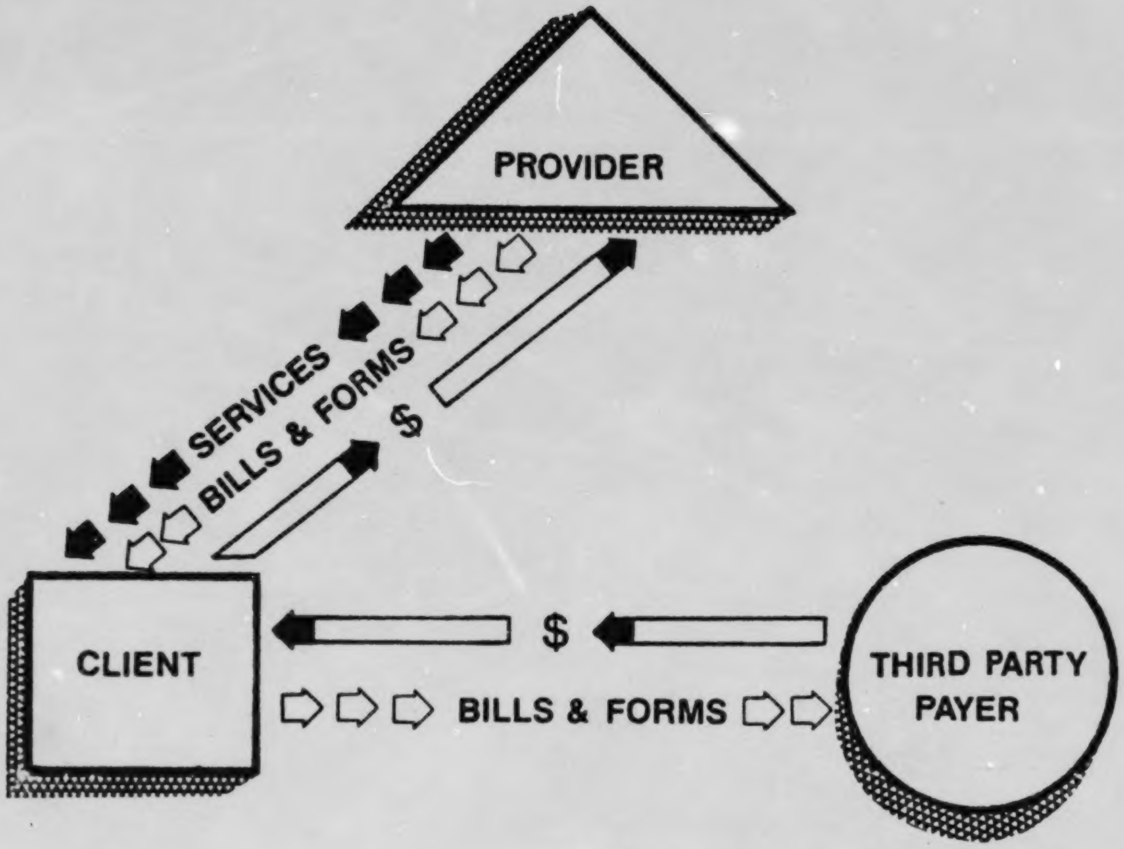
PROVIDER
SERVICES
BILLS & FORMS
$
CLIENT
$
BILLS & FORMS
THIRD PARTY PAYER

FIGURE 1.2. Indirect Reimbursement of Service Provider

Provider Eligibility

Provider eligibility refers to the determination of whether the individual or institution providing services is entitled to be reimbursed, directly or indirectly, by a given third party. Provider eligibility criteria generally relate to the capability of the provider to render quality service. This may be determined directly by the payer (e.g., through an on-site inspection) or indirectly as a result of the provider's having met standards set up by the state or by a credentialing organization such as the Joint Commission on Accreditation of Hospitals (JCAH).

Service Eligibility

Service eligibility refers to a determination of whether the third party will pay for the specific treatment or service rendered to an eligible client by an eligible provider. Generally, third parties will not pay for all services provided to clients and there is considerable variability among providers with respect to the particular services that are covered. The specific services covered are generally designated in the insurance policy (private payers) or in the legislation and/or regulations governing the program (public payers).

Service eligibility is predicated on an acceptable "condition of admission." That is, the payer must accept the illness or disability being treated as an eligible basis for the benefits provided. If, for example, the payer does not specify drug addiction as an acceptable condition for payment of benefits, no reimbursement would be available.

WHO ARE THE PAYERS?

There are many kinds of third party payers. The most commonly known are profit-seeking insurance companies (e.g., Aetna, John Hancock, Prudential, etc.) and Blue Cross/Blue Shield, a non-profit association of medical insurers. Currently, however, the public sector has come to play a significant third party role. For several groups (welfare recipients and other low-income people, the aged, disabled, Social Security beneficiaries, and dependents of military personnel) the federal/state governments serve as the primary third party through programs such as Medicaid, Medicare, and title XX.

There are also specific agencies that might not be thought of as third party payers. The departments of welfare and vocational rehabilitation, for example, can pay for various types of supportive and nonmedical services to low income individuals who might not otherwise be covered by third party payers.

At present, most clients of drug abuse treatment programs, due to economic status, are more likely to be covered by public third parties than by private third party payers.

WHAT IS THE THIRD PARTY PAYMENTS SYSTEM?

The three parties in a third party payments system are clients (or service recipients), service providers, and payers. The likelihood of a given provider's being reimbursed by a particular payer for services to a specific client is related to the three factors of client, provider, and service eligibility. That is, there must be a match between the specific payer's client, provider, and service eligibility requirements and the characteristics of the particular client, provider, and service involved. The specific criteria established for each of these factors is determined by federal and state regulations (in the case of public third parties) and individual company requirements (in the case of private third parties). In the case of public third party payers, federal regulations generally establish certain minimum criteria of client, provider, and service eligibility for each payment program. However, state regulations vary considerably, so that the same payment program may have different eligibility criteria in different states.

It is not possible to give either simple or general directions for obtaining third party payments. Rather, *a determination of the feasibility of obtaining such reimbursement, and the specific procedures to be used in doing so, must be worked out by each service provider. This can be accomplished by determining the various eligibility criteria that must be met for each payer and relating these to the characteristics of your client population, your program, and the type of services offered.* This type of analysis will permit you to assess the likelihood of obtaining third party reimbursements in general and to identify the payers with whom you will stand the greatest chance for success. The specific facts needed for this assessment are given in this manual.

WHY COLLECT THIRD PARTY PAYMENTS?

Third party payments offer several potential benefits to a drug treatment program. These benefits include:

- Source for required "match" funds
- Reduction of dependency on a single funding source
- Expansion and/or improvement of the program
- Preparation for national health insurance
- Improved program credibility

Let us examine some of these benefits in greater detail.

Source for Required "Match" Funds

Historically drug abuse programs have relied heavily on federal "categorical" funding support combined with local matching funds. However, rising health care costs, coupled with funding constraints at all levels of government, have created a real concern.

Alternative sources of funding may need to be identified if local funds are not available. Third party payments may help to alleviate some of the financial burden.

It is important to note that at the federal level there is continued support for services provided under legislative authorities such as Medicaid and Medicare. These are sometimes referred to as "uncontrollable" budget items, as opposed to "controllable" budget items such as categorical program funding. In periods of reduced budgets, the "controllable" budgets are, of course, the more vulnerable. Thus, it is important for drug abuse treatment programs insofar as possible to become incorporated into the system that is more likely to receive continued federal funding support.

Reducing Dependency on a Single Funding Source

Increased reliance on third party payments frees a program from dependence upon any one organization, individual, or political climate; third party payers include many government programs and hundreds of individual insurance companies.

Third party payment also creates a more predictable financial situation. Consider a treatment facility with an annual operating budget of $500,000. Let us assume $250,000 comes from third party reimbursement, with the other $250,000 being a combination of a $150,000 federal grant and $100,000 in local donations. The third party reimbursements may consist of payments from such sources as Medicaid, public social service funds, and/or various private insurers. The particular combination of payers will depend upon the nature of the program's client population. It is unlikely that any single event, short of a national catastrophe, would have a significant effect on funding for the subsequent year with respect to the $250,000 received from third parties and the $100,000 local share. Thus, even in the event of a complete withdrawal of federal support, the program could continue to operate, though at a reduced capacity. On the other hand, let us consider a facility that has a $500,000 annual operating budget, but depends upon a $400,000 grant with $100,000 in donations. It wouldn't take much of a cutback in funding by the granting agency to have a marked impact on the $400,000 budget of that operation. Dependency on funding is less troublesome when spread over a broad base, and, in general, the third party mechanism does just that.

Expanding or Improving the Program

To the extent that third party revenues represent additional funds, they have potential for creating more treatment slots, improving the quality of services offered, or expanding the types of services provided.

Federal requirements regarding accountability for, and use of, third party revenues are set forth in Chapter 1-420 of the Public Health Service (PHS) Supplementations to the Department of Health, Education and Welfare Grants Administration Manual, a portion of which is quoted below:

GRANT RELATED INCOME

> The grantee is accountable to the Government for grant-related income generated by activities performed under PHS grants. Some examples of grant-related income are: proceeds produced by the sale of products or services, such as laboratory tests or computer time; payments received from patients or third-parties for medical or hospital services; and fees for personal services performed in connection with and during the period of the grant-supported activity.

Records of the receipt and disposition of grant-related income must be maintained by the grantee in the same manner as required for the grant funds which gave rise to the income.

Disposition

Except for the special circumstances listed in the paragraph below, all grant-related income shall be treated in accordance with one or a combination of the following options, to be designated in the grant's terms and conditions:

1. Used by the grantee for any purposes that further the objectives of legislation for which the grant was made;
2. Deducted from the total project costs for the purpose of determining the net costs on which the Federal share of costs will be based.

If the terms and conditions of the grant do not specify disposition, the grantee shall select one or a combination of the above options.

(NOTE: Remainder of Chapter 1-420 has been omitted)

Thus, unless the terms and conditions of your grant specify what disposition is to be made of third party revenues, you may select which of the two options will be exercised.*

Preparing for National Health Insurance

It appears likely that there will be some form of national health insurance; what is uncertain is when it will come and what form it will take. It is important for drug abuse programs to develop the capacity to utilize national health insurance as soon as it becomes available. Planning for other types of third party payments will facilitate tying into a national health insurance system.

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*However, state policy or administrative procedures may require that third party income, client fee revenue, etc., be returned to the state treasury or used as an offset to state funding.

Improving Program Credibility

Third party payers consider the quality of care furnished as a significant factor in determining whether they will reimburse beneficiaries for care obtained from a given provider of health services. Thus, third party acceptance of a drug program as an "eligible provider" signifies that the program has met some standard of quality imposed by an "outside" source. The standards of many such payers are quite high and, therefore, provide some validation of the program.

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SESSION 2

FINANCIAL PLANNING: THE HEALTH SERVICES FUNDING REGULATIONS

SESSION 2

LEARNING OBJECTIVES

Participants will attain a general understanding of the type of requirements established by the HSF regulations.

At the end of this session and without the aid of notes, participants will be able to–

- define the purpose of the Health Service Funding (HSF) Regulations;
- identify at least two major reporting requirements of the Health Service Funding Regulations;
- identify at least three topic areas to be highlighted in the reporting of the Health Service Funding Regulations' general plan;
- identify at least two topic areas to be highlighted in the reporting of the Health Service Funding Regulations' financial plan.

SESSION: 2

SESSION REQUIREMENTS	
PERSONNEL	Trainer
TIME	30 minutes
EQUIPMENT	Chalkboard
MATERIALS	Handout (H-2): HSF Regulations Financial Plan Summary Sheet
FACILITY	Large-group meeting room

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
5 min. LG M-L		INTRODUCTION Note to Trainer: *Read sections I-V of the HSF guidelines to prepare for this session. Explain to trainees that you are not an expert on the Health Services Funding Regulations and that you will only summarize the current, basic guidelines. Trainees can refer to their manuals for greater detail and can direct questions of interpretation to Single State Agencies or NIDA.*
	Chalkboard	● State the purpose of the HSF Regulations. *The HSF Regulations were designed to encourage NIDA-funded drug treatment facilities to seek third party reimbursement and direct client payment to the maximum extent possible.*
		● Mention the importance of financial planning in program operations: it is basic to sound administrative management.
		● Note that information on third party payments is vital to financial planning.
25 min. LG M-L	Handout (H-2) (HSF Regulations)	HSF REGULATIONS ON FINANCIAL PLANNING Note to Trainer: *To determine the degree of detail you should use in presenting this session, ask how many trainees are familiar with the requirements of the HSF Regulations.*
		● Explain that HSF Regulations require that programs (1) develop the capability to recover third party reimbursement and direct client payment to the maximum extent possible and (2) report their plans and actions related to TPPs.
	pp. 38-41	● Explain that projects are required to submit a general plan and a financial plan. *The general plan describes how the program will attempt to obtain third party revenues and direct client fees.*
	Financial Plan Summary Sheet	*The financial plan describes the management of third party revenues, and gives other fiscal information.*

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
	p. 39	● Outline the HSF reporting requirements under the general plan: a) Number of contacts made in pursuit of third party payments and the results of these b) Steps that have been set up to bill clients, and the experience in billing clients c) Provider eligibility criteria d) Analysis of client's ability to pay e) Relevant internal operating procedures f) An assessment of the project's capacity, and the utilization of its services ● Outline reporting requirements under the financial plan: a) Management and program objectives and planning assumptions b) Financial management arrangements c) Projection of total income d) Expenditure, cost, and utilization data e) Budget data ● Answer any questions.

SECTION 2

FINANCIAL PLANNING: THE HEALTH SERVICES FUNDING REGULATIONS

Use of the third party payment mechanism creates the need for careful financial planning and management. Good financial planning and management in turn increase the likelihood of obtaining third party payments.

Some type of financial planning had to take place before federal support for your program could be obtained. That is, you had to develop a budget in which you estimated cost of operation during the forthcoming funding year. If you accurately estimated the operating costs, and the federal treasury was not too lean, chances are you got the amount of money you needed. If, on the other hand, you miscalculated expenses, or your grant was smaller than you requested, at some point during the year you had to spend considerable energy and imagination trying to figure out how to shave expenses and still maintain the level of service you planned.

The above procedure is fine so long as federal funds can be relied on for the necessary (or near necessary) level of support. However, in the event that the level of federal support is significantly reduced, you will have to close up shop, reduce services, or find other funds. Finding additional sources of funds gets us to the next level of financial planning--balancing anticipated financial support from a variety of sources with anticipated costs of operation. Relying on more than one source for income requires that you determine what proportion of your projected operating costs can be derived from each source. Among these sources, third party payers must be given serious consideration.

REGULATIONS AND GUIDELINES FOR HEALTH SERVICES FUNDING

With an awareness of the potential resources available through private and public third party funding sources, the Secretary of HEW directed certain health service delivery projects, including drug treatment projects, to work towards supplementing and broadening their financial base, through utilization of third party funds. The Health Services Funding (HSF) Regulations, effective January 1, 1974, are the statement of this policy; the regulations require that drug abuse treatment and other health service delivery projects develop the capability to recover third party reimbursements to the maximum extent possible, so that federal grant dollars will be used most productively.

The following statement of the Acting Assistant Secretary for Health, which introduced the guidelines for implementing the HSF Regulations, clearly expresses the importance of seeking third party reimbursement.

March, 1975

Message from: The Acting Assistant Secretary for Health
Department of Health, Education, and Welfare *

The regulations and interpretive guidelines within this publication reflect the great importance the Department of Health, Education, and Welfare places on increasing the efficiency of the Nation's Health Delivery systems. Health care costs continue to climb at alarming rates, and federal spending must be reduced in order to help curb the current inflationary spiral. In the short term, at least, this means that fewer federal dollars will be available for Public Health Service Health Services Delivery projects. Clearly, if we are to preserve the program gains already achieved, projects need to aggressively pursue support from other funding sources and insure that the services that are provided make the best use of funds without sacrificing quality of care.

These are not easy tasks. For many projects the prospects for third party or patient reimbursements are at best meager, but it is important that we seek reimbursement whenever it is possible and appropriate. As stressed in the guidelines, it is equally important that projects take a hard look at internal operations. This should be a continuous process that involves objective assessment of the reasonableness of the costs of the services provided and actively strives to make the best use of the resources available. The quality of operations is a significant factor in the general acceptance of projects by third party payors and may well influence the nature of project participation in some form of national health insurance.

The Public Health Service regional and headquarters personnel stand ready to assist grantees within the limits of available resources. You should seek this help if you need it. However, outside assistance can only do so much. The ultimate responsibility for complying with these regulations must continue to rest with the grantee.

Theodore Cooper

Theodore Cooper, M.D.

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*Published in Regulations and Guidelines for Health Services Funding. Washington, D.C: Department of HEW, March 1975.

Applicability

The Health Services Funding (HSF) Regulations apply to projects dealing with narcotic addiction, drug abuse, and drug dependence, which are funded under the following authorities:

1. Section 251 of the Community Mental Health Centers (CMHC) Act (42 U.S.C. 2688 k), "Grants for treatment facilities"
2. Section 252 CMHC Act (42 U.S.C. 2688 l), "Grants... for developing specialized training programs, training personnel...and programs of special significance"
3. Section 256 CMHC Act (42 U.S.C. 2688 n-1), "Special projects for narcotic addicts and drug dependent persons"
4. Section 410 of the Drug Abuse Office and Treatment Act (21 U.S.C. 1177), "Special project grants and contracts"

All services projects supported by the National Institute on Drug Abuse are funded under one of these sections.

Requirements

The HSF Regulations require that projects submit a general plan and a financial plan reflecting planning and activity related to third party payments and direct client fees. The general plan describes how the program will attempt to obtain third party revenues and direct patient fees. The financial plan describes the management of third party revenues, and gives other fiscal information. Additionally, the HSF Regulations specify a set of project requirements to be adhered to in implementing the general and financial plans.

The General Plan

The general plan must show how the project is going to seek third party reimbursement and direct client fees. Therefore, it should identify steps already taken, or to be taken, to obtain recognition by third party payers. This should include an assessment of the program's characteristics in relation to the requirements of various third parties. If there are administrative or legislative barriers to obtaining provider status, these should be clearly specified. The plan should discuss the project's intent and actual experience with regard to billing clients directly and an analysis of the target population's ability to pay.

The general plan should include a discussion of those internal operating procedures and systems that have direct bearing on the program's financial management. These include: the statistical and cost-accounting system, intake procedures, recording of patient encounters, and billing and collection procedures.

The program's cost-accounting system is particularly important. It provides the information on which the required fee schedule is developed and it is the basis for the preparation of accurate estimates of operating costs and anticipated revenues (from grants, local share contributions, third party payments, direct client billing, etc.). Further, cost accounting must be relied upon to assist in the development of the administrative procedures required to meet the cash flow problem inherent in a third party reimbursement system.

The general plan should also include an assessment of the project's capacity, an analysis of the level at which it is operating, and the patterns of utilization of its services. If the program is underutilized, the plan should indicate how the number of clients will be increased or how the capacity of the program will be reduced.

The Financial Plan

The financial plan consists of four parts. They are: management and program objectives and planning assumptions; financial management arrangements; projections of total income; and expenditure, cost and utilization data. The first three parts require information for the immediately preceding budget period, the current budget period, and the next budget period. The fourth section requires information for just the preceding and current budget periods.

Management and Program Objectives; Planning Assumptions

The first section of the financial plan identifies planning assumptions that must be made by the project and relates these to their impact on project operations. It requires program managers to make an analysis of needs related to management and program objectives. To provide the desired services, certain employees, space, equipment and supplies are necessary. The objectives should be stated in quantifiable terms, e.g., number of clients being served in various ways. The services provided must be identified, along with realistic registration levels, estimates of third party coverage, method of obtaining necessary facilities and equipment, and approaches to recruiting and training of service and administrative staff.

Budget requirements to satisfy these objectives are then developed by computing the utilization level by type of service and identifying all costs necessary to provide the level of service. These services also may be identified as direct or supportive for later comparison with revenues actually collected.

Financial Management Arrangements

This section discusses activities the project has undertaken in order to obtain support from sources other than the Health Services Administration (HSA) or the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). These sources must be identified and contacts documented. The sources include local, state, federal (other than HSA or ADAMHA) and private agencies, as well as third party payers. The section also identifies the person in the management structure who will pursue the negotiations with third party providers and attempt to obtain other sources of revenue, as well as what percentage of time will be devoted to this function. Finally, future plans for these functions are noted here.

Projections of Total Income

This part of the financial plan includes a Public Health Service (PHS) form called Financial Plan-Summary Sheet. It asks for annualized data concerning the previous year's revenues and the projections of revenue for the current and coming years. This does not mean that you must necessarily show an increase in revenue from non-ADAMHA sources. However, if your level of dependency upon ADAMHA funds is unchanged from year to year, you should be able to state clearly why other sources of revenue are unavailable to you. Stating why other revenues are not available is the proof that attempts have been made to obtain them. The revenue data is identified as fee-for-service or as prepayment, to reflect your cash flow situation. Cash flow problems arise when services are performed in advance of payment for them, as in fee-for-services and insuror-reimbursed arrangements. The categories of revenue encompass every area from federal grants to foundations, endowments and other sources, including direct client and third party payments.

Note: The Financial Plan form must be completed and submitted with all grant applications. Awards to NIDA-supported programs are contingent on receipt of a Financial Plan. (Shown on next page.)

Expenditure, Cost and Utilization Data

This part includes page two of the Financial Plan--Back-Up Information. It is an array of the number of clients who are eligible to have the costs of services paid for by a third party payer, the amount of these costs that has been filled, the amount collected and the per-client amount this revenue represents. Other information is also recorded on this page: the number of clients who receive free services, the target population, the user population, the number of encounters (the number of times that services are used), total costs, and cost per client and per encounter. A statement of total operating costs, total income and a balance is also required.

To develop an acceptable financial plan, you must identify a target population that needs services and for whom you can project the level of service utilization. You must be able to develop a budget to provide those services. You must show that you have made efforts or have the ability to make efforts to capture funds from sources other than ADAMHA. Those sources should include third party payers, both public and private. You must have a means of accounting for funds received previously and funds for which you are applying. You must have procedures for determining whether clients are eligible to have a third party pay the cost of their treatment. Remember, though, that you must not refuse treatment to anyone based on their inability to pay.

Project Requirements

Section 50.105 of the HSF regulations relates to management structure and the methodology necessary to realize the general plan and the financial plan. It requires projects to develop the appropriate organizational structure, management skills, and operating procedures needed to implement the plans.

HEALTH SERVICES FUNDING
FINANCIAL PLAN—SUMMARY SHEET

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Public Health Service

PROJECT IDENT. NO.(S)
(Grant or Contract)

NAME OF INSTITUTION

PROJECT TITLE

42 (18)

	ACTUAL			ESTIMATED			ESTIMATED		
	PREVIOUS BUDGET PERIOD (YEAR)			THIS BUDGET PERIOD (YEAR)			NEXT BUDGET PERIOD (YEAR)		
	PREPAYMENT	FEE-FOR-SERVICE	TOTAL	PREPAYMENT	FEE-FOR-SERVICE	TOTAL	PREPAYMENT	FEE-FOR-SERVICE	TOTAL
I. INCOME									
A. FEDERAL SUPPORT-THIS GRANT/CONTRACT									
B. STATE AND LOCAL GOVT.									
1. STATE									
2. LOCAL									
C. THIRD PARTY PAYORS:									
1. MEDICARE									
2. MEDICAID									
3. OTHER *(Specify)*									
a.									
b.									
c.									
d.									
e.									
4. TOTAL - SECTION C									
D. DIRECT USER PAYMENTS									
E. TOTAL PAYMENTS FOR SERVICES *(C4 + D)*									
F. FOUNDATIONS, ENDOWMENTS, AND OTHER PRIVATE SOURCES									
G. LOANS									
H. OTHER *(Specify)*									
1.									
2.									
3.									
4.									
5.									
I. TOTAL INCOME (A thru H)									
II. EXPENDITURES									
III. BALANCE *(Difference between I & II)*									
A. NET									
B. CUMULATIVE									

Appendix A (26)

PHS-5161 (FORMERLY HSM-735) (PAGE 1)
(REV. 1-7

FORM APPROVED:
O.M.B. 68-R 1341

HEALTH SERVICES FUNDING
FINANCIAL PLAN — (BACK-UP INFORMATION)

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

PROJECT IDENT. NO(S)
(Grant or Contract Nos.)

	ACTUAL—PREVIOUS BUDGET PERIOD					ESTIMATED THIS BUDGET PERIOD		
I. THIRD PARTY FEE-FOR-SERVICE INCOME	BILLED OR TO BE BILLED		AVERAGE PER USER	COLLECTED		TO BE BILLED		AVERAGE PER USER
	NUMBER	AMOUNT		NUMBER	AMOUNT	NUMBER	AMOUNT	
	1	2	3	4	5	6	7	8
A. MEDICARE								
B. MEDICAID								
C. OTHER *(Specify)*								
1.								
1.								
2.								
4.								
5.								
TOTAL—PART I								
II. DIRECT USER PAYMENTS								
A. FULL FEE PAYMENT								
B. PARTIAL FEE PAYMENT								
TOTAL—PART II								

	ACTUAL—PREVIOUS BUDGET PERIOD				ESTIMATED THIS BUDGET PERIOD			
III. PREPAID CAPITATION INCOME *(By Source):*	NO. OF USERS	NO. OF ENROLLEES	INCOME	AV. PREMIUM AMOUNT	NO. OF USERS	NO. OF ENROLLEES	INCOME	AV. PREMIUM AMOUNT
A.								
B.								
C.								
D.								
E.								
F.								
TOTAL—PART III								
IV. NON-PAYING USERS *(Not included in Parts I, II, or III above)*		▨	▨	▨		▨	▨	▨

V. OTHER INFORMATION	PREVIOUS BUDGET PERIOD	THIS BUDGET PERIOD
A. TARGET POPULATION		
B. USER POPULATION		
C. TOTAL NUMBER OF ENCOUNTERS		
D. TOTAL OPERATING COST		
E. TOTAL INCOME		
F. COST PER USER (D ÷ B)		
G. COST PER ENCOUNTER (D ÷ C)		

FOOTNOTES

PHS-5161 (PAGE 2)
(REV. 1-76)

Specific recommendations are that a project have:

1. A governing body that has full legal authority and responsibility for overall conduct of the project
2. A chief executive officer who has been delegated the authority for administration of the project
3. Sufficient qualified personnel to carry out the financial and administrative requirements of the project
4. An organization chart, job descriptions, and function statements that delineate relationships among the major staff functions and among the staff, grantees, advisory board, etc.
5. Financial data and reports that accurately identify costs and use standard definitions and generally accepted accounting practices
6. Current personnel and administrative policies and procedures
7. Registration and other direct data systems that identify third party eligibility, ability to pay, and actual services rendered
8. Billing and collection policies and procedures
9. Assessment procedures to measure direct service personnel's productivity and levels of service utilization

Section 50.105 requires that policies be instituted to determine the ability of clients to pay for services. Clients must be charged in accordance with this determination. However, the section stipulates that charges shall not be a barrier to services.

This section requires programs to bill for those services that are covered by legal obligation of a third party, including the federal government. This is an "every reasonable effort" requirement to become familiar with potential third party payers and their requirements. It is recommended that contacts be made with Single State Agencies, state Medicaid and/or title XX authorities, and relevant private third party payers to obtain state-specific information.

Additionally, you are required to have operative procedures for determining which clients are eligible to have their treatment paid for by a third party. If a significant part of the cost of your program is to be reimbursed by a third party payer, you must have a written agreement with that payer. If your program has tried and failed to obtain such an agreement, these efforts must be documented.

Maximum Coordination of Activities with Other Health Services

The regulations require projects to coordinate their efforts with other agencies serving the target population to preclude an overlap of services. This requirement presumes referral activity in areas such as vocational rehabilitation, legal services, etc.

3

SESSION 3

KEY ISSUES

SESSION 3

LEARNING OBJECTIVES

Participants will become familiar with the issues of client eligibility, provider eligibility, and service eligibility and with their impact on garnering third party payments.

At the end of this session and without the aid of notes, the participants will be able to–

- identify the procedure that best describes the process for determining a client's eligibility for third party payments;
- identify the three important factors in obtaining provider eligibility;
- identify at least three sources of information on service eligibility;
- identify at least four reasons for client resistance.

SESSION: 3

SESSION REQUIREMENTS	
PERSONNEL	Trainer
TIME	2 hours, 20 minutes
EQUIPMENT	Chalkboard
MATERIALS	Handout (H-3): Client Third Party Eligibility Checklist Prepared flip charts (F-4, F-5, F-6)
FACILITY	Large-group meeting room

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Session 3: KEY ISSUES

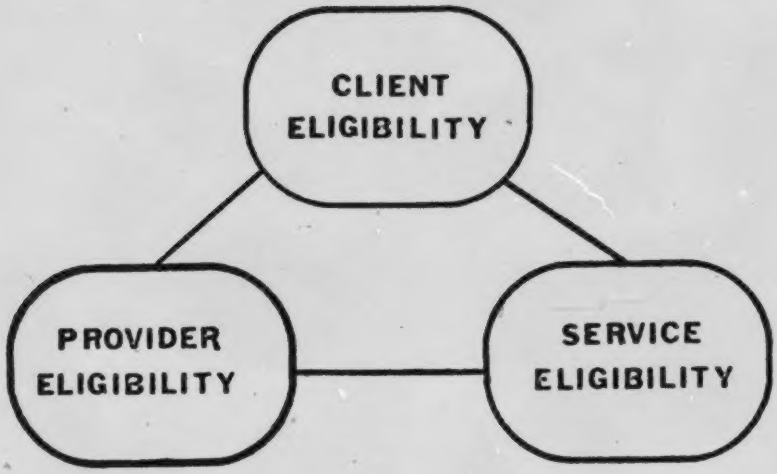
TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
5 min. LG M-L	Chalkboard Flip Charts (F-4, F-5, F-6)	INTRODUCTION ● Identify the key issues of third party payments *(see sample flip charts)*. *client eligibility* *provider eligibility* *service eligibility* ● Note the importance of considering the issues of eligibility.
30 min. LG M-L	p.67	CLIENT ELIGIBILITY ● Define client eligibility. *Client eligibility refers to the client's qualification for reimbursement by a third party.* ● Discuss client eligibility using the following outline for major points to be covered: *(Refer to the text of key issues for more complete information)* a) To be eligible for reimbursement by a third party payer, a client must either have some form of private medical insurance, or must meet the criteria for public assistance benefits. Criteria for public assistance relate to age, physical condition, or economic status. *(Discussed in detail in Section 4)*
	p. 67	b) Determining client eligibility is an information-gathering and review function. Data should be collected at time of interview. c) Determination should be the responsibility of a staff TPP specialist *(e.g., intake-counselor)*.

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
		CLIENT ELIGIBILITY (CONT'D)
	Handout (H-3) (Client Third Party Eligibility Data Form)	● Note the possibility of using the Client Third Party Eligibility Data Form (see p.*228*) with a program's intake form to obtain the following information: Private insurance coverage (self, spouse, dependent) Employment status, group coverage Public assistance benefits/eligibility for benefits Enrollment in HMO
	pp. 71-72	e) Validation of client data is essential in establishing eligibility. *(Refer to p. 71 for means of validation)*.
	p. 72	● Be certain trainees understand the importance of maintaining confidentiality of client records.
		● Answer any questions.
30 min. LG D		**DISCUSSION**
		● Note that staff must be aware of client resistance when trying to gather eligibility data that may be considered sensitive.
		● Mention that trainees should think about how to deal with client resistance.
		● Initiate a discussion by giving an example of client resistance and asking pertinent questions:
		Entering your program is the 17-year-old son of a career military officer. His response to any request for information relating to third party reimbursement is extreme resentment. He is becoming hostile.
		Why do you think the client is resistant to questioning?
		What can you do? Not do? What factors must be considered.

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
35 min LG M-L		PROVIDER ELIGIBILITY
	p. 72	- Define provider eligibility. *Provider eligibility refers to the provider's qualifications to be reimbursed by a third party.*
	p. 73	- Define and discuss credentialing terms: accreditation, licensure, certification. (as defined by the National Commission on Accrediting)
	p. 74	*Licensure is the process by which an agency grants permission to persons meeting predetermined qualifications to engage in a given occupation and/or use a particular title, or grants permission to institutions to perform specified functions.*
	p. 74	*Accreditation is the process by which a agency or organization evaluates or recognizes a program of study or an institution as meeting certain predetermined qualifications or standards. It shall apply to institutions and their program of study or their services.*
		Certification is the process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.
		- Note that JCAH has developed and evaluated accreditation standards and will begin accrediting programs in September 1976.
	Table 3.1 p. 74	- Explain that licensing is performed primarily at the state level. *(See Table 3.1 for a list of states that have adopted licensing requirements.)*

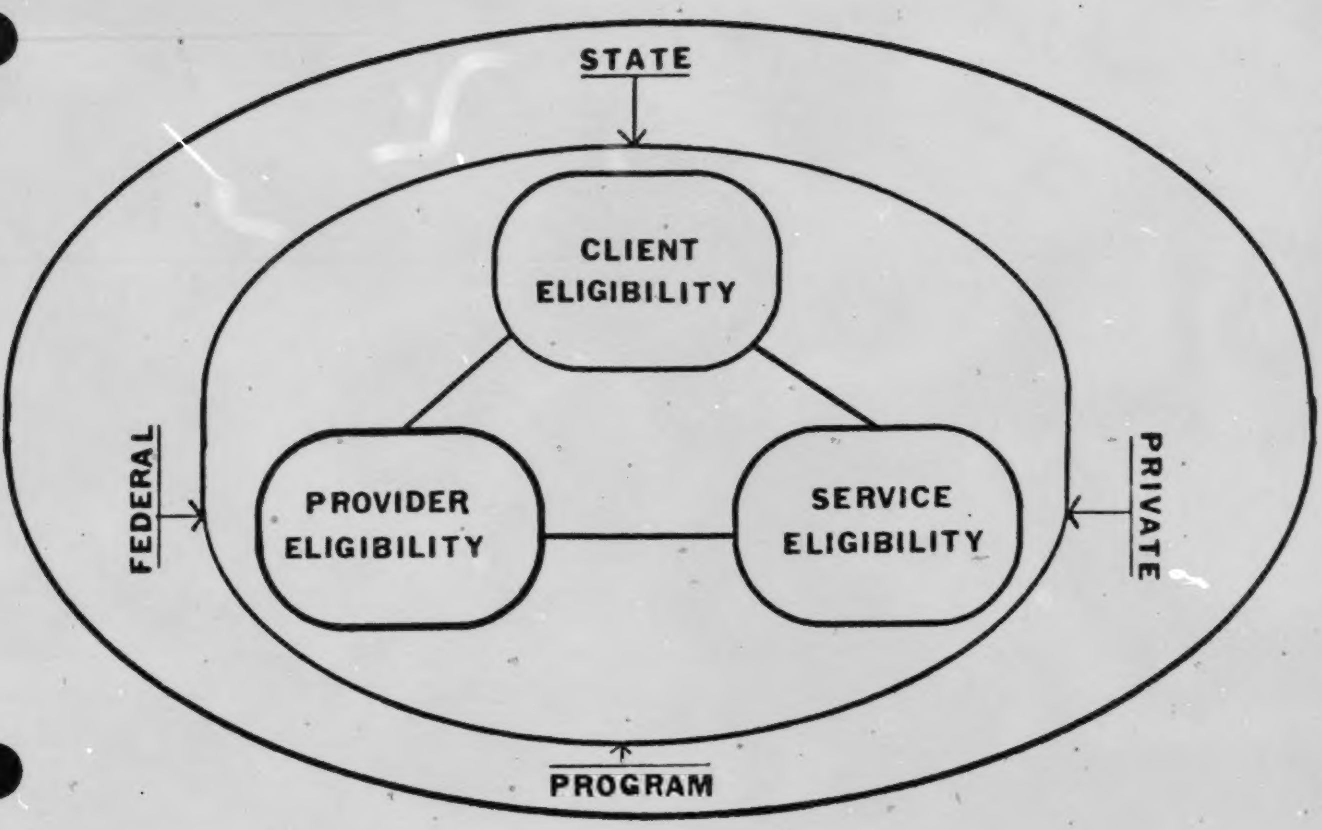
IME/ ORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
		● Note that staff members should meet certain credentialing requirements. *Generally, either key staff members and/or a given proportion of the total staff must be licensed or certified before a program can be credentialed, particularly in the case of accreditation. Because there is a precedent for reimbursing physicians' services and services provided under a physician's supervision, reimbursement may be easier to obtain if the program employs licensed physicians.* ● Note that in states without licensing procedures, some payers have established their own standards. ● List some possible ways to meet licensing requirements a) Seek affiliation with a licensed unit *(example: hospital, mental health facility)* b) Add licensed physicians and nurses to staff c) Contact a Single State Agency for help ● Answer any questions
10 min	p. 77	SERVICE ELIGIBILITY (Services Covered) ● Define service eligibility. ***Serv**ice eligibility refers to the types of treatment and services for which a third party will pay, if provided by an eligible provider to an eligible client.* ● Explain how to determine what services are covered. a) Defined in a private insurance policy b) Defined in federal or state regulations governing the payment program *(if a public payer)*

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
		Note: Some of these definitions may need to be interpreted by the responsible state agency, for example: "Clinic Services," or "Other Rehabilitative Services." ● Explain that services may not be covered if the "condition of admission" (the illness or disability) is excluded from coverage. *For example, if drug addiction is not a covered condition, the payer will not pay for an otherwise covered service.*
20 min.		SUMMARY ● Briefly summarize the points covered in this session. ● Mention that the next session will examine potential third party payers and general client, provider, and service eligibility criteria for each. ● Answer any questions.


CLIENT ELIGIBILITY
PROVIDER ELIGIBILITY
SERVICE ELIGIBILITY

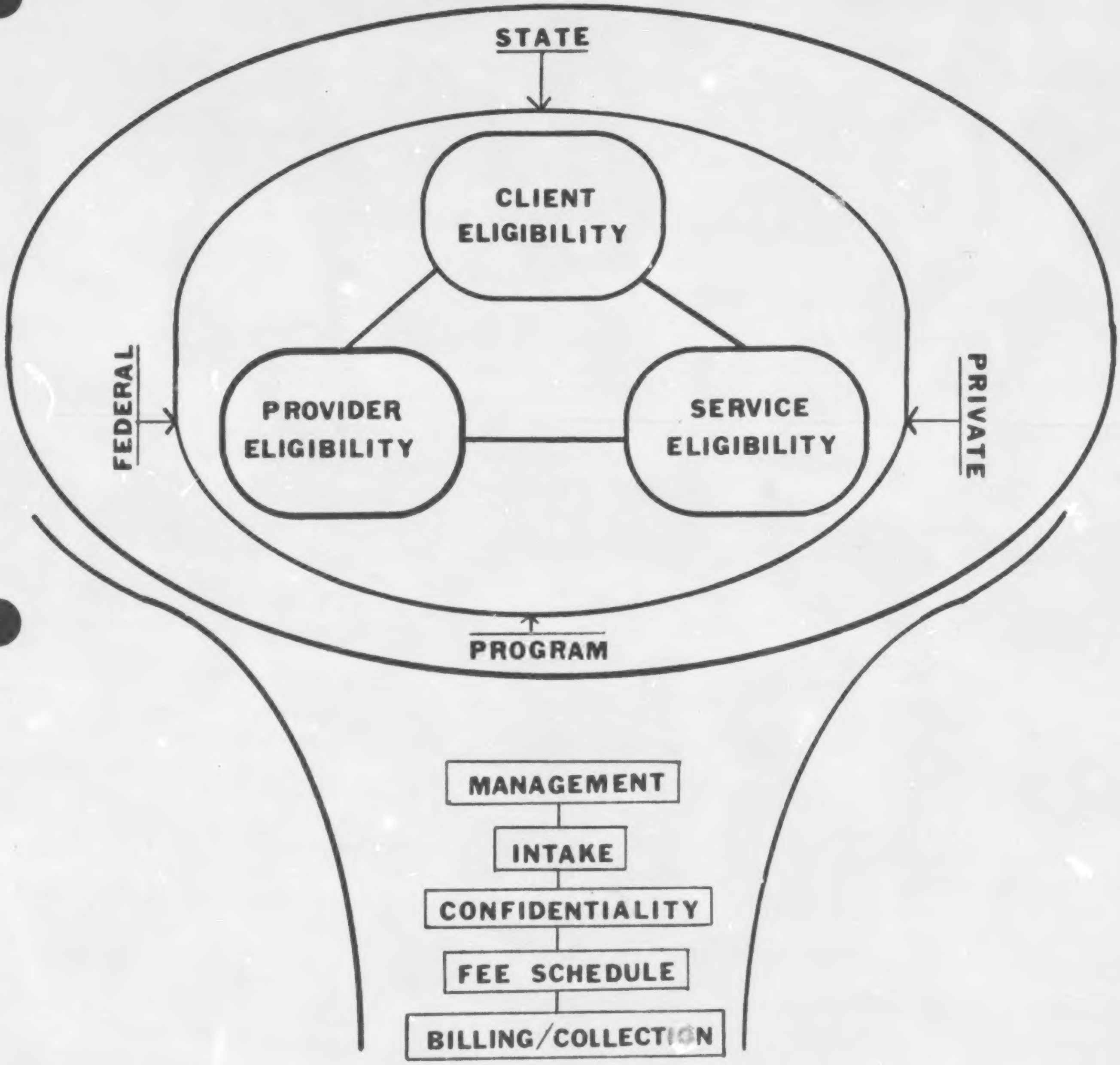
Sample Flip Chart F-4

KEY ISSUES IN THIRD PARTY PAYMENTS


STATE
CLIENT ELIGIBILITY
FEDERAL
PROVIDER ELIGIBILITY
SERVICE ELIGIBILITY
PRIVATE
PROGRAM

Sample Flip Chart F-5

FACTORS AFFECTING KEY ISSUES


STATE
CLIENT ELIGIBILITY
FEDERAL
PROVIDER ELIGIBILITY
SERVICE ELIGIBILITY
PRIVATE
PROGRAM
MANAGEMENT
INTAKE
CONFIDENTIALITY
FEE SCHEDULE
BILLING/COLLECTION

Sample Flip Chart F-6

PROGRAM FACTORS AFFECTING KEY ISSUES

SECTION 3

KEY ISSUES

There are three basic issues that must be addressed in establishing a third party payments system:

- Eligibility of the individual receiving services (client eligibility)
- Eligibility of the individual or institution providing the services (provider eligibility)
- Elibibility of the services provided (service eligibility)

These factors are key issues because the requirements of each must be met in order to secure third party reimbursement. This section discusses these three types of eligibility.

CLIENT ELIGIBILITY

Client eligibility is the entitlement of a client to have all or part of the costs of the services he receives from a program reimbursed by a third party. To be eligible for such reimbursement, the individual must either have some form of private medical insurance or meet the criteria established by federal and state agencies for publicly financed medical or social services. Client eligibility criteria for publicly financed programs generally relate to age, physical condition, or economic status. (These are discussed in some detail in Section 4.)

Determining Client Eligibility

Determining whether a client has, or is eligible for third party payments is basically an information-gathering and review function. Information on which to make such a determination must be obtained from each client. It is recommended that this function be performed at the time of intake so that the required data are collected along with other client information. This data must then be reviewed to establish the client's eligibility for third party reimbursement.

Determination of client eligibility for third party reimbursement should be the responsibility of at least one staff member, preferably an intake counselor or member of the administrative staff. This individual, who may be referred to as the Third Party Payment (TPP) Specialist, should become intimately familiar with the client eligibility criteria of those third party payers deemed to be relevant to the program, as well as with the forms and procedures required for obtaining benefits from these payers. After locating each state agency that is responsible for a third party payment program, the TPP Specialist should also identify one or two knowledgeable individuals in each agency, and establish a working relationship with them. Such contacts will be extremely helpful in obtaining answers to technical questions about the payment program, and certifying and obtaining benefits for eligible clients.

Determining a client's eligibility for third party coverage will require the TPP Specialist to: 1) determine if the client has private medical insurance; 2) determine if the client has coverage provided by a public third party; or 3) determine if the client is eligible for coverage by a public third party payer. The last determination is accomplished by relating the client characteristics data recorded on the intake form to the client eligibility criteria of the various public third party payers. Where a potential reimbursement source is identified in this way, the client should be assisted in applying for assistance from the relevant agency.

Information Needed to Determine Client Eligibility

The first thing to be determined is whether or not the client has third party coverage. There are several factors that should be investigated to help determine this. The following possibilities should be explored for both incoming and enrolled clients:

- The client may have private individual insurance (e.g., Blue Cross/Blue Shield, Travellers, Aetna).
- The client may be covered under a policy held by a parent or spouse.
- If the client is employed, he may be covered by a group policy.
- If employment has recently been terminated, the client's group policy may have a conversion privilege to an individual policy.
- The client may be entitled to, or receiving benefits or services from, a public assistance program such as Aid to Families with Dependent

Children, Supplemental Security Income, Medicaid, Medicare, title XX, etc., and thus be entitled to benefits that will cover some of the services to be provided.

- The client may be enrolled in a Health Maintenance Organization (HMO) that has contracted with the treatment program to provide services to addicts.

In assessing eligibility for private insurance, it may be necessary to assist the client in determining if any coverage possibilities apply. Here are some suggestions:

- Ask the client to look through his or her wallet, purse, stash bag or whatever, to see if there is an insurance identification card.
- Ask if a parent or spouse has insurance.
- Let the client call a spouse/parent/co-worker to check on whether there is some insurance coverage.
- If the client is employed or has been employed recently, ask if he remembers whether the company provides health insurance.
- Suggest that the client call the employer to find out about coverage from the personnel office.
- Determine if the client has some type of insurance coverage brochure prepared by his employer or is aware of anything like it. You may want to show the client an example of such a booklet.

Note: The following actions require prior written permission from the client. See Section 5 for discussion of confidentiality issues.

- Call the family's insurance broker or agent, if the client or some member of his family has private medical coverage.
- Call the personnel section of the client's employer to determine if he is covered by a group policy and the nature of the coverage.

If, as a result of one or more of the preceding steps, you have determined that the client has private health care insurance coverage, the next step is to determine if it covers the treatment of drug addiction. If so, you will need to know such details as: provider eligibility requirements, what services are covered, and what, if any, limitations on coverage exist (e.g., maximum length of time and/or cost, exclusion of condition if it existed prior to the writing of the policy, etc.).

It is not likely that the client will know this information. Therefore, it may be necessary to obtain such details either by examining the client's insurance policy itself, or through the aforementioned contacts with employer or insurance agent.

> *NOTE: If some or all of your program's services are covered under the client's policy, record this fact along with such data as name and address of underwriter, client's policy number, effective dates of policy, specific type of services covered, and any limitations on the coverage. This data should be maintained so that it is readily accessible to the individuals responsible for billing.*

If the client does not have private health care insurance, determine his eligibility for benefits provided by one of the publicly financed medical or social service programs. This will necessitate obtaining information regarding income (individual and family), employment status (individual and family), welfare status (current welfare recipient or eligible), dependency status, nature and extent of physical/mental handicaps (the latter may require that arrangements be made for formal testing), and other data relevant to state requirements. If the client appears to be eligible for this type of coverage, he should be assisted in applying for the appropriate program. The TPP Specialist may merely provide the client with information on the steps he must take to obtain coverage or actually work with him in doing this. Obviously, there is a practical limit to the actual amount of assistance you can give to any one client. However, some individuals will need more support than others in finding their way through the maze of paperwork and processes that tend to overwhelm the applicant.

If the client is not eligible for any form of third party reimbursement, a determination should be made (based on program policy) as to whether the client's income level (individual or family) warrants that he be charged for the services provided.

> *Note: Whatever action is taken regarding reimbursement for services (third party payments, direct client payment, or no charge), it is imperative that it be recorded and readily available to the individuals responsible for billing.*

Validation

We have seen that much information needs to be collected regarding your clients; a good bit of it goes considerably beyond that which you are currently collecting. It may appear to be not only burdensome, but an invasion of (or at least an assault on) privacy. Nonetheless, you need not only to ask for personal information, but to verify what you are told. This brings us to the need for validation.

Why Validation?

If a program relies on third party revenue to cover some of its operating costs, accurate client data is essential in order to provide the basic information that will be required by the third party payers. Inaccurate or incomplete client data will certainly complicate, and may preclude, obtaining reimbursement. In the long run, both the program and its clients suffer.

Means of Validation

Listed below are some techniques for validating personal information:

- Name: Standard identification such as a driver's license, Social Security card, draft card, birth certificate, or marriage license
- Address: Same as above as well as recently postmarked mail, phone book listing
- Date of birth: Birth certificate, driver's license, baptismal certificate
- Income: Paycheck stub, W-2 Form
- Third party insurance: Identification card; contact employer insurance representative, or welfare agency.

NOTE: Written permission must be obtained from the client prior to any inquiry.

In situations where it is not possible to formally validate information, a signed and witnessed affidavit may be accepted by the third party payer.

A Word About Confidentiality

There is a problem with confidentiality that is peculiar to substance abuse programs. Normally, a person seeking medical services shows an insurance card, and the treatment facility calls to get forms for treatment and to determine the client's eligibility. In the case of substance abuse, the very telephone call without the client's permission could be a violation of his rights of confidentiality. (See Section 5 for a more detailed discussion of confidentiality). It is also a clear violation of federal law and makes the program staff liable to severe penalties. Even if one calls and does not identify the nature of the problem, the very fact that a facility is known in the community for treating substance abuse problems could violate the confidentiality to which the client is entitled. Therefore, two specific policies are recommended at this stage.

- Do not make a telephone call without the client's written permission and his full knowledge that you are going to call and ask for details of his insurance policy. Written permission is mandated by federal regulations.
- When you make the telephone call, do not discuss the nature of the problem. Just state that the client has come to your facility for medical treatment and you would like details concerning the nature of his coverage and want to have the appropriate forms sent to you.

PROVIDER ELIGIBILITY

Another key issue in third party payments is provider eligibility. This is the acceptance by a third party of a provider as a legitimate source of services for its beneficiaries. Thus, an eligible client must receive services from an eligible provider. In nearly all cases, approval of a facility means that the service provider has met some type of formal credentialing requirements established by either the state in which it operates (e.g., licensure), a professional organization, or a recognized accrediting institution. Many third party payers do not attempt to approve or disapprove the eligibility of each individual provider.

To do so would be both impractical and beyond their level of expertise. Rather, they accept as eligible those providers who meet standards developed by recognized and acceptable outside sources. However, the specific type of accepted credentialing varies among the third parties. Some insurance companies have established their own standards for provider eligibility; these may be in addition to or in lieu of formal credentialing. Such payers will generally make their own on-site reviews of the provider's facility to determine eligibility.

Credentialing

Credentialing is a generic term that encompasses the processes of accreditation, licensure, and certification. These terms are defined by the National Commission on Accrediting as:*

> Licensure: The process by which an agency of government grants permission to persons meeting predetermined qualifications to engage in a given occupation and/or use a particular title, or grants permission to institutions to perform specified functions.
>
> Accreditation: The process by which an agency or organization evaluates and recognizes a program of study or an institution as meeting certain predetermined qualifications or standards. It shall apply only to institutions and their program of study or their services.
>
> Certification: The process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.

Further amplification of the distinction between accreditation and licensing is provided in a report prepared by University Research Corporation, which states:**

> Licensing sets forth the minimum qualifications and duties which must be complied with in order for an agency or program to legally engage in the type of activity which is the subject of licensure. Accreditation, however, requires adherence to a higher standard and is usually voluntary rather than mandatory.

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*Study Commission, Study of Accreditation of Selected Health Educational Programs, National Commission on Accrediting, 1972.

**Steinberg, Sheldon; Batista, Angel Luis; Bisconti, Ann; Gumberg, Irene. Credentialing of Drug Abuse Treatment and Rehabilitation Workers. Washington, D.C.: University Research Corp., February 1975.

Licensure

Licensing of drug abuse treatment programs is performed at the state level. As of January 1975, 29 states and Puerto Rico had established licensing requirements, and an additional 12 states were in the process of adopting such requirements. The status of licensing legislation in each state (as of January 1975) is given in Table 3.1.

Licensing generally represents the minimum requirements for provider eligibility. Thus, programs operating in states not having licensing standards may, at the present time, be ineligible for reimbursement from some third parties. In the absence of licensure, some Single State Agencies (SSAs) have established provisions for program approval by the SSA, which may be acceptable to some payers. Recognizing the importance of licensure, NIDA has strongly recommended the development of licensing procedures for drug abuse treatment programs in all states.*

The importance of licensing cannot be overemphasized. Therefore, it is recommended that where state licensure for drug abuse treatment programs does not exist, Single State Agencies initiate actions toward this goal. Provisions for licensing or accreditation might include--**

1. minimum standards for maintenance and operation of each type of drug abuse treatment and rehabilitation facility which each such facility must meet in order to qualify for licensure;
2. a description of the specific methods for licensing the facilities which qualify under the standards and identification of the persons or agencies responsible for carrying out such methods; and
3. a description of the sanctions or penalties imposed for noncompliance and the incentives, if any, offered for compliance.

Accreditation

Formal accreditation of drug abuse treatment programs does not exist at the present time. However, the Joint Commission on

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*NIDA Notice to SSAs, number 36, dated March 3, 1976.

**Federal Register, Section 546.107, August 28, 1973.

Accreditation of Hospitals (JCAH) has developed standards for the accreditation of four categories of programs: comprehensive rehabilitation, short-term detoxification, emergency, and assessment and referral.* As of June 1976, JCAH had field tested these standards and was in the process of making some revisions to them. The revisions are scheduled to be completed and the finished standards issued on or about May 1977. The initial standards, which will not be altered significantly as a result of the revisions, will remain in effect until that time.

JCAH plans to begin its accreditation process in September 1976. This accreditation will be performed in four phases:

> Phase 1, Self-Evaluation. In the self-evaluation phase, programs assess themselves using a series of checklists and questionnaires provided by JCAH. The completed forms, together with some additional documentation covering operational policies and procedures are then submitted to JCAH for review. When this review is completed, the program will receive a report indicating specific weaknesses that should be remedied before proceeding to Phase 2. Programs may take up to one year to complete this phase, the cost of which is $120.
>
> Phase 2, Policies and Procedures Review. In this phase, detailed information regarding the administrative and operational characteristics of the program is submitted to JCAH, which reviews the material and makes a preliminary assessment of the program in terms of its accreditation criteria. The cost of this phase is $600.
>
> Phase 3, On-site Review. At this time, a JCAH surveyor will conduct an on-site inspection of the facility to evaluate it in terms of the accreditation criteria established for that type of program. The cost for this phase is $310 per surveyor-day and generally requires two surveyor-days to complete.
>
> Phase 4, Accreditation. This phase constitutes JCAH's review of the on-site inspection report and final determination on the granting of accreditation. The cost of phase 4 is $400.

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*Copies of the JCAH Standards for Drug Abuse Treatment and Rehabilitation Programs may be obtained by sending $7.50 per copy to: Joint Commission on Accreditation of Hospitals, 875 N. Michigan Avenue, Chicago, Illinois 60611.

Table 3.1
Status of Licensing of Drug Abuse Programs

State	Legislation Enacted	State	Legislation Enacted
Alabama	No	Missouri	No
Alaska	No	Montana	No
Arizona	Yes	Nebraska	Yes
Arkansas	No	Nevada	No
California	Yes	New Hampshire	No
Colorado	Yes	New Jersey	Yes
Connecticut	Yes	New Mexico	No
Delaware	Yes	New York	Yes
District of Columbia	No	North Carolina	No
Florida	Yes	North Dakota	No
Georgia	Yes	Ohio	Yes
Hawaii	No	Oklahoma	Yes
Idaho	No	Oregon	No
Illinois	Yes	Pennsylvania	No
Indiana	Yes	Rhode Island	Yes
Iowa	Yes	South Carolina	Yes
Kansas	No	South Dakota	Yes
Kentucky	Yes	Tennessee	No
Louisiana	No	Texas	No
Maine	Yes	Utah	Yes
Maryland	Yes	Vermont	Yes
Massachusetts	Yes	Virginia	Yes
Michigan	Yes	Washington	Yes
Minnesota	Yes	West Virginia	Yes
Mississippi	No	Wisconsin	No
		Wyoming	No

Source: Credentialing of Drug Abuse Treatment and Rehabilitation Workers, University Research Corporation, Contract No. ADM-45-74-158, NIDA, February 1975.

The total cost for accreditation of an average program will be approximately $1,750; however, a program may stop the accreditation process at any phase.

Summary: Provider Eligibility

Having accreditation and licensure indicates that a program meets certain operational and physical criteria. But these two processes also often require that staff members meet certain credentialing requirements. Generally, either key staff members and/or a given proportion of the total staff must be licensed or certified before a program can be credentialed, particularly in the case of accreditation.

What this means to you is quite simple: YOUR PROGRAM AND PROBABLY SOME OF YOUR STAFF SHOULD BE CREDENTIALED IN ORDER TO MAXIMIZE THIRD PARTY REVENUES.

Because there is a precedent for reimbursing physicians' services and services provided under a physician's supervision, reimbursement may be easier to obtain if the program employs licensed physicians.

However, certification and the formal credentialing of other staff is also important and will continue to grow in importance. Therefore, in many cases, success in garnering third party payments will be related to a program's effectiveness in upgrading the technical capabilities of, and in subsequently credentialing, its staff.

Remember, the essence of provider eligibility is to prove program legitimacy and quality of care to the third parties. This type of proof generally means credentialing of the program and its staff.

SERVICE ELIGIBILITY

The final key issue in obtaining third party payments, service eligibility, refers to the types of treatment and services for which a third party will pay, if provided by an eligible provider to an eligible client.

The specific services covered by a third party are spelled out in the insurance policy (if a private payer) or in the federal/state rules and regulations governing the payment program (if a public third party). Since wide variations in services covered exist from payer to payer, it is important to identify the requirements of each payer with whom you might be dealing and relate them to the services provided by your program. In this regard, note that although the services covered by a public payer will be uniform for a given state or jurisdictional area, those covered by private payers will vary according to the type of policy held by a client. Thus, in the latter case, it will be necessary to examine the client's insurance policy to determine exactly what services are covered, noting those that correspond with services offered by your program. This information then needs to be recorded for subsequent use by the billing staff.

SUMMARY: DETERMINATION OF ELIGIBILITY

This section has discussed the basic issues of client, provider, and service eligibility. The following section will examine potential third party payers noting the specific client, provider, and service eligibility criteria of each. Additionally, programs must obtain state-specific and/or company-specific client, provider, and service eligibility criteria, and by comparing these criteria with their own program, service, and client characteristics, determine which third parties are the most relevant to them. Once this has been accomplished, contact should be made with those payers from whom reimbursements will be sought, to initiate their authorization of your program as a provider. The general procedures for obtaining such authorization are examined in the following section; however, specific procedures vary among providers.

SESSION 4

THIRD PARTY PAYERS

SESSION 4

LEARNING OBJECTIVES

Participants should attain sufficient understanding of third party payers to permit them to make a preliminary determination of the most likely reimbursement sources for their program.

At the end of this session and without the aid of notes, the participants will be able to–

- list the first steps to be taken by a program to identify potential third party payers;
- identify the third party payers most relevant to drug abuse treatment programs;
- define institutional providers;
- define individual providers;
- define the two types of institutional providers that may be applicable to drug abuse programs;
- identify the three categories of individuals who are eligible for Medicaid;
- identify at least three federal client eligibility criteria of the Medicaid program;
- identify at least five federal service eligibility criteria of the Medicaid program;
- identify at least four provider eligibility criteria usually assigned by the state Medicaid programs;
- identify the four federal client eligibility criteria of the title XX programs;
- identify the factors most commonly used by private insurance companies in determining individual institutional provider eligibility;
- identify at least three services drug programs might make use of that are offered by state vocational rehabilitation programs.

SESSION REQUIREMENTS	
PERSONNEL	Trainer(s) (1 or 2) Facilitators (2 or 3 recommended)
TIME	4 hours, 30 minutes to 5 hours, 15 minutes
EQUIPMENT	Chalkboard
MATERIALS	Flip charts (F-7, F-8, F-9, F-10, F-11, F-12) Workshop packets (Appendix 1) W-1: Medicaid-Title XX Workshop W-2: Third Party Payers Workshop
FACILITY	Large-group meeting room Small-group meeting rooms (3 or 4)

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
10 min LG M-L		OVERVIEW
	Flip Chart (F-7)	• Explain that this session discusses third party payment systems most relevant to drug abuse treatment programs. *Note that the systems discussed here represent the most likely sources for reimbursement; programs should not expect to obtain reimbursement from all or even most of them.*
		• Mention that you will examine each payer and its eligibility criteria--information that should be used by programs to identify the payers most appropriate to their needs.
		• Explain that the information given will be incomplete: the discussion of public payers will consider primarily federal regulations, and only the general requirements of private payers will be mentioned.
	Appendix D	• Suggest that additional information can be obtained from SSA's and resources listed in Appendix D.
20 min LG M-L		MEDICAID (Title XIX of Social Secuirty Act, 1965)
		• State the purpose of the program. *Medicaid was established to encourage states to develop unified medical assistance programs for recipients of federal aid. It has subsequently been expanded to provide coverage to other low-income individuals.*
		• Note that the program is federally funded but administered by the states.
		• Explain the federal funding: *Federal support ranges from 50-83 percent, based on a formula that compares the average per capita income of the state with that of the country as a whole.* *It is an "open-ended appropriation," matching 50 percent of a state's expenditures for specific categories of individuals.*

Session 4: THIRD PARTY PAYERS

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
	Flip Chart (F-8)	Client Eligibility
		• Note that there are three categories of individuals who are eligible for Medicaid: categorically needy, categorically related medically needy, and noncategorically related medically needy.
	pp. 128-129	• Define these three categories.
		• Explain which categories must be covered according to the regulations and which are optional.
	Table 4.1 p. 130	• Note that the specific categories of individuals eligible for Medicaid in each state is shown in Table 4.1.
		• Explain that additional federal requirements regarding client eligibility relate to age, income, and state residency.
		Services Covered
	p. 131	• List the services that must be provided by the state to eligible clients.
	pp. 132-133	• List those services that may be offered at the option of the state.
		Note that services to addicts may not be included or may be specifically excluded, and that, though not specifically included, they may be covered.
		• Identify services relevant to drug abuse programs *(i.e., physician's services, clinical services, prescribed drugs such as methadone, and other rehabilitative services).*
	Table 4.2 pp. 123-125	• Note that a summary of services offered in each state is shown in Table 4.2.
	p. 127	

Session 4: THIRD PARTY PAYERS

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
		Provider Eligibility
	p. 133	• Define institutional providers and individual providers. *An institutional provider is the hospital, skilled nursing facility, intermediate care facility, or clinic providing services.* *An individual provider is the physician or health care technician who provides services to the client.*
		• Note that approval by a state credentialing body is required for both institutional and individual providers.
		• Note that services rendered by a provider must meet the state's definition of "medical or remedial services."
		• Explain that states establish eligibility criteria and that institutions must meet requirements relating to (1) health, (2) humane treatment, (3) sanitation, (4) physical facilities (including type of construction, space, and accommodations per person) (5) fire and safety, (6) staffing (number and qualifications), (7) client records, and (8) administrative and fiscal arrangements.
	p. 133	• Note that there are two types of institutional providers that may be applicable to drug abuse programs. *Clinics are defined as facilities that are not part of a hospital but organized and operated to provide medical care to outpatients (most likely to be relevant)* *Intermediate Care Facilities (ICF) are defined as institutions licensed under state laws to provide regular health-related care to individuals who do not require the degree of care that a hospital or skilled nursing facility is designed to provide, but who, because of their mental or physical condition, require care and services (above the level of room and board) that can be made available to them only through insitutional facilities.*

Session 4: THIRD PARTY PAYERS

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
	pp. 127-129 p. 134	• Mention the requirements to which an approved provider may be subject.
		• Note that when a program does not meet the Medicaid eligibility criteria, individual providers operating within the facility may be able to collect individually for the services they render to clients.
	Appendix B	• Refer trainees to state-specific Medicaid information in Appendix B. *Remind trainees that further details concerning eligibility criteria and operating procedures should be obtained from either the Single State Agency or local Medicaid authority. Information for contacting these services is also in Appendix B of the Trainee Handbook.*
	pp. 136-137	• Note that the suggested procedure for Medicaid certification is outlined in the text.
		• Explain limits on reimbursement as established by the states. *Define reasonable cost and reasonable charge.*
		• Mention relevance of Medicaid to drug programs, considering the variability in coverage among states, the coverage of AFDC workers and/or dependent children, and coverage of disabled *(addicts may not qualify).*
		• Answer any questions.
45 min.		TITLE XX (Grants to States for Services, October 1, 1975)
LG M-L	Flip Chart (F-6)	• State purpose of the program. *The purpose of title XX is to establish a consolidated program for federal assistance that will encourage states to provide social services and cash assistance to help low-income individuals and families obtain employment, achieve self-care, and attain family stability.*
	p. 138	*(List the five goals).*
		• Distinguish between title XX's emphasis and that of Medicaid and Medicare programs:

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
		Title XX emphasizes the provision of social services to eligible individuals in contrast with the Medicaid and Medicare programs, which emphasize medical services.
	p. 138	● Explain federal funding of title XX.
	p. 139	● Note that title XX represents a major change in the nature of federal assistance to states: previously, federal funds could only be used to assist specified categories of individuals; title XX gives states latitude in determining: a) *What services will be made available* b) *Who will be eligible for services* c) *Where and how services will be provided*
	pp. 140-142	● Discuss public participation under title XX: The review of a state's services plan by that state's citizens instead of by the federal government. (CASPP)
	p. 142	Services Covered
		● List the specifications for services covered under title XX: a) *Services must be consistent with title XX goals, with at least one service directed at each of the five goals.* b) *At least three services must be provided for SSI recipients.* c) *Family planning and foster care services must be provided to AFDC recipients, if the state has an AFDC program.*
		● Mention services that might be covered under these specifications.
		● Note that states may include services to drug addicts, but that they are not required to do so.

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TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
		• Note that trainees should obtain information from their state welfare departments or SSAs about specific services covered in their states to determine whether title XX would be a likely source of funds.
	Flip Chart (F-10) p. 143	Client Eligibility • Note that client eligibility is limited to low-income individuals: categorically needy *(income maintenance status)* or those able to meet an income test *(income status)*.
	pp. 143-144	• Explain income maintenance status and income status classifications.
	Flip Chart (F-11) Table 4.3 p. 145	• Note that individuals in the income status category may be charged a fee, depending on their income level. (Refer to Table 4.3 and chart on p.147)
	Figure 4.1 p. 146	*A fee must be charged if the family income falls between 80%-115% of the adjusted median income for a family of four.* *A fee may be charged individuals whose income is less than 80%.*
		• Note that determination of client eligibility may be made either by the state or, at the state's option, by the provider.
		• Note the options of the state in terms of client eligibility. a) *State can set maximum income level below 115%.* b) *It can limit eligibility for a given service to specific categories of recipients.* c) *It can vary income limits by category of recipient.* c) *It can vary income limits by service.*

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
	p. 147	Provider Eligibility ● Note that specific requirements for provider eligibility are established by the state and vary considerably. ● Note that requirements generally relate to: administrative management quality of care delineation of services reimbursement
	p. 147	● Explain the Purchase of Services Agreement (PSA) that must be negotiated between the provider and the state agency. Note the requirements of the PSA.
	Appendix C	● Note that trainees should contact state agencies to learn the specific terms and conditions necessary for each state. Refer to Appendix C for a list of agencies and state-specific data about title XX plans.
30 min SG	Medicaid Assessment Form Title XX Assessment Form Facilitator	WORKSHOP ● Divide trainees into small groups of approximately six people from the same state, if possible. If there are not at least four individuals from one state, groups can be made up of individuals from two or more states as needed. *An alternative would be to divide participants by treatment modality represented and intermix SSA representatives appropriately.* ● Distribute the Medicaid Assessment Form and Title XX Assessment Form to each trainee.

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TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
	Appendices B & C	• Explain that trainees are to use their state Medicaid and title XX charts (Appendices B and C) to fill out these forms.
		• Encourage participants to discuss how they obtained the information necessary to respond positively to some of the assessment form questions. *If the assessment forms indicate that all participants in a group are at a similar point in terms of obtaining Medicaid and title XX payments, they may want to work together to plan strategies to meet the requirements.*
	Facilitator	• Use a facilitator in each group to help trainees define issues identified in completing the forms.
15 min LG	Chalkboard	DISCUSSION (Workshop)
		• Return to large group to discuss these issues.
		• Note any unresolved issues on the chalkboard for participants to consider when they return to their programs. Note possible resources for resolution of these questions, *(i.e., SSA, state Medicaid, or title XX agency)*.
		• Discuss the relevance of Medicaid and title XX to drug programs. a) Note that relevance depends on the particular state plan *(i.e., services covered, client and program eligibility criteria for each state)* b) Note that title XX has created increased competition among potential recipients for the states' social services funds. c) Stress that SSAs should demonstrate to those states not yet offering services to addicts, the importance of providing these services.
		• Answer any questions.

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
10 min LG M-L	p. 149	MEDICARE Title XVIII • State the purpose of Medicare *Medicare was designed to be a major medical insurance plan for eligible individuals who are at least 65 years old or disabled.*
	pp.149-153	Services Covered • Note that Medicare covers most medical services provided to addicts by physicians and licensed medical facilities.
	p. 153	Client Eligibility • Mention that coverage to drug addicts is specifically included. • Note that client eligibility is limited to those 65 or over or disabled. *(Note that addicts are not generally considered as disabled.)*
	p. 154	Provider Eligibility
	Figure 4.3 p. 157	• Note that there are high standards for institutional providers, but that all licensed physicians are eligible.
	Table 4.4 p. 158	• Refer trainees to Table 4.4 for a list of state agencies responsible for Medicare.
		• Answer any questions.
20 min. LG M-L	p. 161	VOCATIONAL REHABILITATION (VR) • State the purpose of Vocational Rehabilitation *Vocational Rehabilitation is a federal program designed to provide services and materials for the rehabilitation of those whose physical or mental disabilities inhibit their employment, but who can reasonably be expected to become gainfully employed as a result of VR services.*
		• Outline distribution of funds, noting that because of considerable state autonomy in determining use of funds, services offered and eligibility criteria vary greatly among states.

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TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
		Services Covered
	p. 161	- Note that covered services are broadly defined as any item or service considered necessary to render a handicapped individual employable.
	p. 162	Client Eligibility - Note that according to the Vocational Rehabilitation Act of 1973 priority must be given to individuals defined as *severely disabled.* - Explain that criteria were established that allow an individual who does not fall into one of the defined categories to be classified as severely disabled. Substance abuse is not included in the list of severely disabling conditions but it may meet these criteria.
		Provider Eligibility
	p. 162	- Explain that a state rehabilitation agency usually works in conjunction with a drug abuse treatment center to provide additional services to the program's clients. - Give examples of these additional services: employment counseling skill training placement - Mention that specific information may be obtained from the local Vocational Rehabilitation agency. - Answer any questions and stimulate a discussion concerning the potential of vocational rehabilitation services for drug abuse clients and programs. Encourage SSA staff to research state regulations and disseminate this information to program staff.

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IME/ ORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
10 min LG M-L		CHAMPUS--Civilian Health and Medical Program of the Uniformed Services
	p. 163	• State the purpose of CHAMPUS. *CHAMPUS is a comprehensive hospital and medical health benefit program for dependents of active duty, retired, and deceased personnel, plus retired members of the military entitled to retirement retainer or equivalent pay.* • Note that the program only reimburses for services, it does not offer any prepaid programs.
	p. 164	Services Covered • Note that CHAMPUS covers any outpatient or inpatient treatment considered acceptable medical practice.
		Provider Eligibility
	p. 164	• Note that inpatient facilities must be licensed by the state and that outpatient facilities must be approved by the fiscal administrator.
	Table 4.5 p. 167	• Explain that drug centers seeking reimbursement status must be approved by the national CHAMPUS office in Denver and by the "fiscal administrator," *(an intermediary organization like Blue Cross that processes claims).*
		• Note that CHAMPUS maintains quality control and distributes reimbursements through the fiscal administrator for outpatient services, and through the Denver office for inpatient services. • Mention that CHAMPUS funding is relevant to drug programs only if there is a reasonable client population of military dependents, and only if the medical standards are adequate. • Answer any questions.

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
5 min. LG M-L		FOOD STAMPS, 1964
	p. 169	• State the purpose of the food stamps program. *The Food Stamp Act of 1964 established a program to distribute food subsidized by federal and state governments.* Client Eligibility • Note that the only criteria are income and unemployment of "employable" members of the household. • Note that addicts participating in a treatment program who qualify on the basis of income are eligible for stamps. • Note that residenital treatment centers may be reimbursed for providing meals to an eligible client. *Refer trainees to their manual for the procedures for obtaining stamps.*
	Table 4.6 p. 174	*Table 4.6 gives a list of regional offices.*
A:15 min. LG M-L		PRIVATE THIRD PARTY PAYERS *Note to the trainer: This section can be presented in one of two ways. Option A (15 min.) uses a lecture format and Option B (45 min.) allows trainees to work individually or in small groups. An outline for Option A follows; instructions for Option B are on page 109.* *Option A*
	p. 172	• Note that health policies are offered by almost every kind of insurance company, as well as by unions, fraternal organizations, and companies formed to cover specific occupations. • Note that these are usually divided into two types: mutual companies *(nonprofit)* stock companies *(profit seeking)* • Mention that policies can be issued for a group or an individual.

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
		Services Covered
	p. 172	• Explain that there is an enormous range in services covered: these vary among companies and among policies from the same company.
	pp. 172-174	• Note the types of coverage generally available: hospitalization *(covers inpatient services)* major medical *(covers a major portion of both inpatient and outpatient services)* hospital indemnity *(provides cash benefits unrelated to specific services)*
	p.175	Provider Eligibility
		• Explain that specific provider eligibility criteria will vary among carriers.
		• Note that individual providers must generally be "licensed practitioners" and institutional providers must be licensed by the state or be properly accredited. *Note that JCAH standards may become the criteria for reimbursement by many private payers.*
		• Note that programs should identify potential payers and contact them for information on eligibility criteria and procedure for obtaining provider status.
		• Discuss the fact that legislation has been enacted in some states and is pending in others in an attempt to ensure medical coverage of drug addiction.
	Table 4.7 p. 181	*Refer to Table 4.7 for a summary of benefits allowable under state legislation as of October 1975.*

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OPTION B: PRIVATE PAYERS WORKSHOP

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
B:45 min SG/I		PRIVATE THIRD PARTY PAYERS: WORKSHOP WORKSHOP ● If Option B is used, note that this task may be performed individually or in small groups. ● Ask trainees to read again the section in the Trainee Handbook concerning private third party payers and to write down any questions about obtaining reimbursement from private payers. ● Then ask trainees to develop tentative plans for obtaining reimbursement *(for example--How do you determine the number of current and future clients who have private medical insurance? What changes would be required in your program to meet the eligibility criteria of private payers?)*
G D		DISCUSSION (Workshop) ● Have trainees return to the large group. ● In the large group, discuss questions raised and some of the tentative plans developed in the small groups. Help the group develop some specific steps that programs should follow to determine the feasibility of reimbursement from private payers and of achieving provider status.

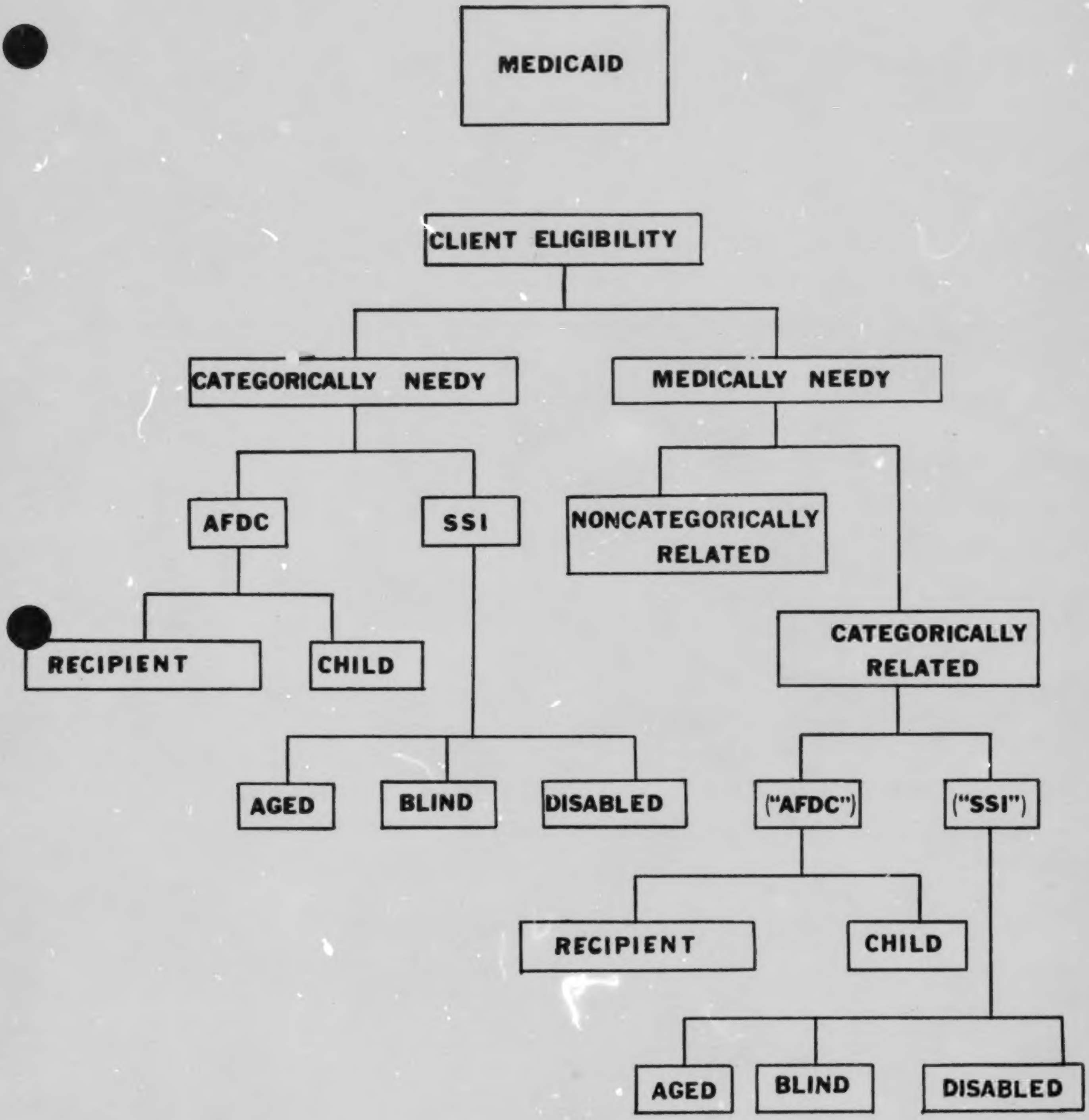
TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
10 min LG M-L	Flip Chart (F-12) p. 177	HEALTH MAINTENANCE ORGANIZATION (HMOs), 1973
		- State the purpose of HMOs.
		Health Maintenance Organizations are organized systems of health care that provide or otherwise assure the delivery of comprehensive health maintenance and treatment services to a voluntarily enrolled group of individuals in a geographic area.
		- Note that enrollees are charged a fixed, prenegotiated fee (capitation payment vs. "fee for service") that entitles them to the services offered by the HMO.
	p. 179	- Explain that the HMO Act of 1973 encourages development of HMOs by authorizing temporary financial support in the form of grants, contracts, and loan guarantees for feasibility studies, planning, initial development, and expansion of HMOs.
		To qualify for assistance, the Act requires an HMO to offer a comprehensive set of basic health care services, including treatment for drug and alcohol abuse. The HMO must either provide these services or arrange to have them provided.
		- Note that programs should contact the HMO in their area to discuss contracting for drug treatment services to HMO clients.
5 min LG M-L		NATIONAL HEALTH INSURANCE (NHI)
	p. 180	- State the purpose of National Health Insurance.
		National Health Insurance would be a way to make health care services available to the general population through a federally assisted, prepaid benefits system.
	Table 4.8 p. 183	- Note that as of January 1976 there were five bills to provide this coverage before Congress. Have trainees refer to Table 4.8, which shows the drug abuse coverage proposed in these bills.

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
		• Note that a NHI bill will most likely provide some type of coverage for drug addicts and that preparation of a program for third party payments will facilitate use of NHI *(for example, credentialing, organization, and management requirements will be similar.)*
15 min LG D		DISCUSSION • Encourage questions about third party payers.
30 min SG	Payer Priority List	WORKSHOP • Divide trainees into the same small groups as earlier, or divide according to treatment modality represented *(e.g., TC, methadone maintenance)*. Divide SSA representatives among the groups as evenly as possible. • Distribute the Payer Priority List. • Ask group members to complete the Payer Priority List, following the directions on the form. Trainees should then discuss their choices. • Ask groups to select one representative to summarize the results to the large group.
20 min LG D		DISCUSSION (Workshop) • Ask representatives to present their group's findings. • Encourage comments and questions from the group.

MAJOR THIRD PARTY PAYERS

- MEDICAID
- MEDICARE
- TITLE XX
- VOCATIONAL REHABILITATION
- CHAMPUS
- PRIVATE THIRD PARTY PAYERS
- FOOD STAMPS
- HEALTH MAINTENANCE ORGANIZATIONS
- NATIONAL HEALTH INSURANCE

Sample Flip Chart F-7


MEDICAID
CLIENT ELIGIBILITY
CATEGORICALLY NEEDY
MEDICALLY NEEDY
AFDC
SSI
NONCATEGORICALLY RELATED
RECIPIENT
CHILD
CATEGORICALLY RELATED
AGED
BLIND
DISABLED
("AFDC")
("SSI")
RECIPIENT
CHILD
AGED
BLIND
DISABLED

Sample Flip Chart F-8

CLIENT ELIGIBILITY FOR MEDICAID

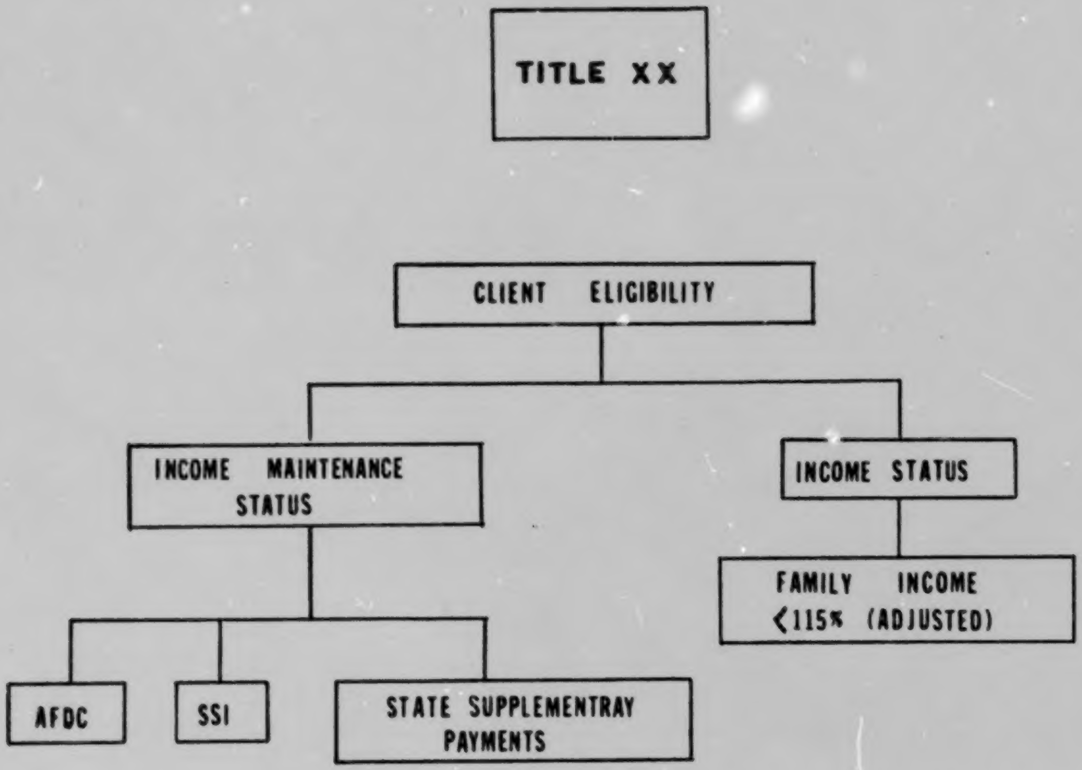
TITLE XX

DESCRIPTION

- FEDERAL STATE PROGRAM PROVIDING SOCIAL SERVICES TO LOW INCOME INDIVIDUALS
- EFFECTIVE OCT. 1, 1975
- NO NEW $
- MORE FLEXIBILITY
  - SERVICE RECIPIENTS
  - TYPE OF SERVICE
  - WHERE SERVICE OFFERED
- PUBLIC PARTICIPATION

Sample Flip Chart F-9

MAJOR CHARACTERISTICS OF TITLE XX

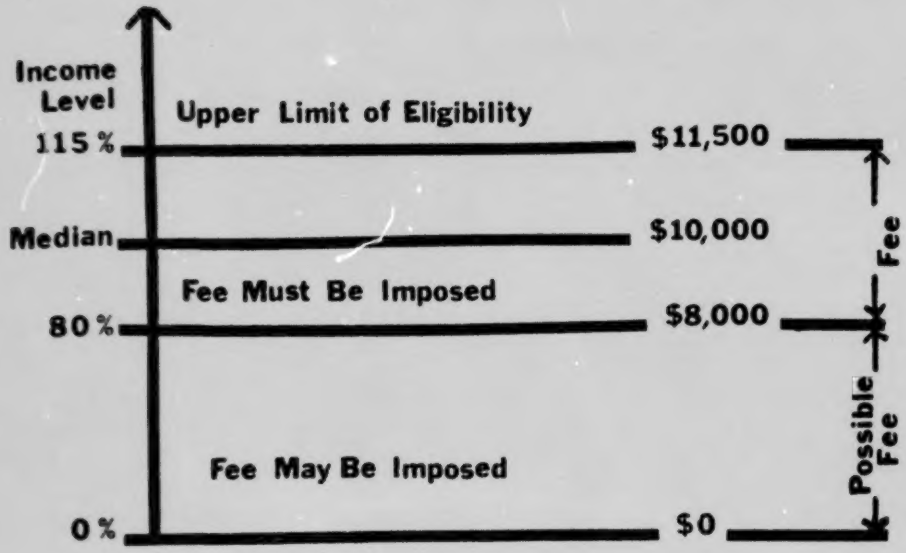

TITLE XX
CLIENT ELIGIBILITY
INCOME MAINTENANCE STATUS
INCOME STATUS
FAMILY INCOME <115% (ADJUSTED)
AFDC
SSI
STATE SUPPLEMENTRAY PAYMENTS

Sample Flip Chart F-10

CLIENT ELIGIBILITY FOR TITLE XX

TITLE XX

Relationship Between Income Level and Fee-For-Service Requirement



Sample Flip Chart F-11

HEALTH MAINTENANCE ORGANIZATION

CHARACTERISTICS

- ORGANIZED SYSTEM OF HEALTH CARE
    - Physicians
    - Outpatient Facilities
    - Inpatient Facilities
- COMPREHENSIVE MEDICAL SERVICES
    - Provides For All Needed Health Care Services
- AGREED UPON SERVICES
    - HMO & Consumer
- VOLUNTARY ENROLLMENT
- GEOGRAPHIC

Sample Flip Chart F-12

SECTION 4

THIRD PARTY PAYERS

This section discusses those third party payment systems that are most relevant to drug abuse treatment programs. This does not mean that any given program can expect to obtain reimbursement from all or even a majority of them. Various factors must be considered such as differing provider/client eligibility requirements, the nature of services covered, specific state regulations, etc. However, the systems discussed here represent the most likely sources for reimbursement. Each system is explained and its service, client, and provider eligibility criteria examined. By relating this information to the characteristics of your particular program you will be able to identify which third party payment systems will be most appropriate to your needs. Subsequent efforts can then be expended to obtain further details regarding specific client/provider/service eligibility requirements of those individual payers who are the most likely potential reimbursers for your program; you can then effect whatever program modifications may be required to meet their eligibility criteria.

The following discussion is divided between public and private third party payers. The major distinctions between these two groups relate to their financing mechanism, client eligibility requirements* and operational basis.**

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*Public eligibility criteria generally limit services to individuals who are economically disadvantaged, physically disabled, or aged, often at no cost to the beneficiaries, while private payers provide coverage on a fee basis only.

**Federal and state regulations versus independent company policies.

MEDICAID

Medicaid (officially known as title XIX of the Social Security Act -- Grants to States for Medical Assistance Programs) was established in 1965 as part of the federal-state public assistance system. It is currently in operation in 50 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

The original purpose of the program was to encourage the states to develop unified medical assistance programs for recipients of federally assisted payments. Subsequent objectives were to expand the nature of medical services provided and extend coverage to other low-income individuals.

The program is supported by both federal and state funds, but administered at the state level. In order to receive federal monies, certain types of coverage are mandatory and coverage must be provided for certain categories of individuals. Beyond these stipulations, states may choose to include additional types of services and/or other categories of individuals. Thus, the nature and scope of coverage vary widely.

Federal support ranges from 50 percent to 83 percent, on the basis of a formula that compares the average per capita income of the state with that for the country as a whole. This formula permits greater federal support for those states having a higher proportion of low-income residents. The nature of federal support is what is officially termed an "open-end appropriation," as it is not limited to a specific dollar amount. The actual amount of the federal payment is directly related to the amount of money spent by the state for services to specific categories of individuals (identified below). For example, if a state receiving a 50 percent federal match should expend $1,000,000 in a given quarter for Medicaid, it would receive $500,000 from the federal treasury.

Client Eligibility

There are three categories of individuals who are eligible for Medicaid:

1. Categorically Needy

   Individuals who qualify for cash assistance under one of the following programs, whether or not they are actually receiving such assistance:

- Title IV-A of the Social Security Act -- cash aid (assistance) to Families with Dependent Children, AFDC
- Title XVI of the Social Security Act -- Supplemental Security Income (SSI) for the Aged, Blind, and Disabled
- A state program supplementing title XVI

Coverage for all individuals falling into one of the above categories is mandatory, and federal financial assistance is provided on the basis of the aforementioned formula.

2. Categorically Related Medically Needy

Individuals who meet the nonfinancial requirements of the Categorically Needy whose income and resources* exceed the maximum allowed for that category, but are insufficient to permit them to meet the costs of necessary medical services.

Coverage for this category of recipient is optional; however, if a state selects this option, federal financial assistance is provided on the same basis as for the Categorically Needy.

3. Non-Categorically Related Medically Needy

Individuals who do not meet either the financial or nonfinancial eligibility criteria established for the Categorically Needy (see above) but who are deemed by the state to lack sufficient income to pay for necessary medical services.

Since no federal monies are available for this category, states have complete freedom in defining the eligibility criteria. (As of June 1976, only five states--California, Kansas, Maryland, New York and Pennsylvania--provided this type of coverage.)

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*"Resources" refers to tangible assets owned by an individual such as stocks and bonds, life insurance, jewelry and other personal property (generally, only if in excess of a specified amount), etc. The specific items considered as resources will vary from state to state.

Table 4.1

Categories of Eligible Individuals under Medicaid, by State.

	Categorically Needy	Categorically Related Medically Needy	Non-Categorically Related Medically Needy		Categorically Needy	Categorically Related Medically Needy	Non-Categorically Related Medically Needy
Alabama	X			Montana	X	X	
Alaska	X			Nebraska	X	X	
Arizona	X	X		Nevada	X		
Arkansas	X	X		New Hampshire	X	X	
California	X	X	X	New Jersey	X		
Colorado	X			New Mexico	X		
Connecticut	X	X		New York	X	X	X
Delaware	X			North Carolina	X	X	
District of Columbia	X	X		North Dakota	X	X	
Florida	X			Ohio	X		
Georgia	X			Oklahoma	X	X	
Hawaii	X	X		Oregon	X		
Idaho	X			Pennsylvania	X	X	X
Illinois	X	X		Rhode Island	X	X	
Indiana	X			South Carolina	X		
Iowa	X			South Dakota	X	X	
Kansas	X	X	X	Tennessee	X	X	
Kentucky	X	X		Texas	X		
Louisiana	X			Utah	X	X	
Maine	X	X		Vermont	X	X	
Maryland	X	X	X	Virginia	X	X	
Massachusetts	X	X		Washington	X	X	
Michigan	X	X		West Virginia	X	X	
Minnesota	X	X		Wisconsin	X	X	
Mississippi	X			Wyoming	X		
Missouri	X						

The specific categories of individuals eligible for Medicaid in each state are shown in Table 4.1.

Additional federal requirements regarding client eligibility criteria relate to age, income, and state residency.

Age: Any individual 65 years or older, and any child under 21 who is classified as a "dependent child" under AFDC, must be covered.

Income: Income requirements are established by the state and, therefore, vary considerably.

State Residency: All residents of a state must be covered regardless of length of residency.

What this means is that, for the most part, client eligibility for Medicaid is limited to:

- AFDC recipients
- Dependent children of AFDC recipients under 21 years old
- Individuals who are 65 years of age or older
- Individuals who are blind
- Individuals who are disabled and qualify for Supplemental Security Income (SSI). In order to qualify, individuals must be unable to work for a period of one year as a result of a physical or mental condition other than drug addiction.

Services Covered

Required Services

Medicaid requires states to provide eligible clients with certain services. These are:

- Inpatient hospital services other than service in an institution for tuberculosis or mental diseases
- Outpatient hospital services
- Other laboratory and X-ray services

- Skilled nursing facility services other than services in an institution for tuberculosis or mental diseases
- Early and periodic screening, diagnosis, and treatment (EPSDT) of physical and mental defects in eligible individuals under 21
- Family planning services
- Physicians' services
- Home health care services

Optional Services

The following services may be offered at the option of the state:

- Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law, such as podiatrists and chiropractors
- Private duty nursing services
- Clinic services
- Dental services
- Physical therapy and related services
- Prescribed drugs, dentures, prosthetic devices, and eyeglasses
- Other diagnostic, screening, preventive, and rehabilitative services
- Inpatient hospital services and skilled nursing facility services, for individuals aged 65 or over, in an institution for tuberculosis or mental disease
- Other medical and remedial care recognized under state law and specified by the Secretary, such as whole blood, Christian Science practitioners' services, and care in Christian Science sanitoria, skilled nursing homes for persons under 21, emergency hospital services, and transportation

- Intermediate care facility services
- Inpatient psychiatric hospital services for individuals under 21

A summary of Medicaid services offered in each state is shown in Table 4.2. This table demonstrates the high degree of variability that exists among the states in the type of coverage provided.

Provider Eligibility

Under Medicaid, the state determines the specific requirements for both institutional providers (e.g., hospital, skilled nursing facility, intermediate care facility, clinic) and individual providers (e.g., physician, health care technician) are determined by the state. Approval by a state credentialing body is required for both institutional and individual providers. The services rendered by a provider must meet the state's definition of "medical or remedial services." Individual providers may be physicians, other practitioners licensed as medical practitioners by the state, or health care technicians (i.e., individuals who meet federally approved proficiency qualifications as opposed to educational, professional, or other formal criteria).

Specific types of requirements that institutional providers must meet relate to factors such as: 1) health, 2) humane treatment, 3) sanitation, 4) physical facilities (including type of construction, space, and accommodations per person), 5) fire and safety, 6) staffing (number and qualifications), 7) client records, and 8) administrative and fiscal arrangements.

In addition, many states require a formal contract or purchase of services agreement with a provider. In virtually all cases, a provider must obtain a vendor number to be used in submitting bills for services to the Medicaid authority.

There are two types of institutional providers that a state may approve for Medicaid that may be particularly applicable to drug abuse treatment programs. These are:

- Clinics: Defined as facilities that are not part of a hospital but organized and operated to provide medical care to outpatients

- Intermediate care facilities (ICF): Defined as an institution licensed under state law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment that a hospital or skilled nursing facility is designed to provide, but who, because of their mental or physical condition, require care and services (above the level of room and board) that can be made available to them only through institutional facilities

The states whose Medicaid programs cover clinic and ICF services are noted in Table 4.2.

Generally, drug abuse treatment programs are more likely to fall under the category of "clinics" than of an ICF. However, in 12 states, clinics are not eligible providers and in an additional 13 states, clinic services are limited to the Categorically Needy.

Once approved as a provider, a facility may be subject to the following requirements:

- Financial records are subject to periodic audit and financial reports may be required by the state Medicaid authority.
- Inpatient care (in short-stay hospitals) must be certified as medically necessary and must be periodically reevaluated during the extent of the patient's stay. This process, known as concurrent review, will eventually extend to all providers and become the responsibility of the Professional Standards Review Organizations (PSRO) in each of 203 geographic areas around the country.

Where a program does not meet the Medicaid eligibility criteria, individual providers (e.g., physicians, laboratory technicians) working in the facility may be able to collect individually from Medicaid for the services they render to clients. Where this type of arrangement is used, Medicaid reimbursement may be made:

> (A) to the employer of such physician, dentist, or practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer; or (B) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service . . . .*

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*Social Security Act, paragraph 1902(a) (32).

Table 4.2

MEDICAID SERVICES—STATE-BY-STATE

(As of January, 1, 1975.)

Medicaid services are subject to definition (sometimes restrictive) by each State's program.

● offered only to the categorically needy¹ + offered to the categorically and medically needy¹	Emergency Hospital Services	Prescribed Drugs	Dental Services	Eye Glasses	Prosthetic Devices	Physical Therapy and Related Services	Private Duty Nursing	Care for Patients 65 or Older in Institutions for Mental Diseases	Optometrists' Services	Podiatrists' Services	Chiropractors' Services	Care for Patients 65 or Older in Institutions for Tuberculosis	Clinic Services	Skilled Nursing Facility Care—Persons Under 21	Other Diagnostic, Screening, Preventive, or Rehabilitative Services	Intermediate Care Facility Services	Care for Patients Under 21 in Psychiatric Hospitals
Alabama	●	●		●	●				●			●		●		●	●
Alaska	●		●					●								●	●
Arizona		●	●	●					●	●							
Arkansas	●	●	●		●			●			●	●	●	●		●	●
California	+	+	+	+	+	+		+	+	+	+	+	+	+	+	+	+
Colorado	●	●			●	●		●		●				●		●	●
Connecticut		+	+	+	+	+	+	+	+	+	+		+	+	+	+	+
Delaware		●				●		●		●		●	●			●	
Dist. of Col.	+	+		+	+	+		+	+	+		+	+	+	+	+	+
Florida	●	●	●	●	●			●	●			●				●	
Georgia		●	●	●	●		●	●	●	●		●		●	●	●	
Guam	+	+	+	+	+	+			+				+	+			
Hawaii	+	+	+	+	+	+			+				+	+	+	+	
Idaho	●	●							●	●	●		●	●		●	
Illinois	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Indiana	●	●	●	●	●	●	●		●	●	●		●	●	●	●	
Iowa	●	●	●	●	●	●			●	●	●			●		●	
Kansas	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	+
Kentucky	+	+	+		+	+		+				+	+	+		+	+
Louisiana	●	●			●			●				●	●	●	●	●	●
Maine	●	+	+	+	+	+	+	+	+	+	+	+	●	+	+	●	+
Maryland	+	+	+	+	+	+		+	+	+	+	+	+			+	
Massachusetts	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Michigan	+	+	+	+	+	+		+	●	+	+	+	+	+	+	+	+
Minnesota	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Mississippi		●	●					●	●			●		●		●	
Missouri	●	●	●	●				●	●			●					
Montana	+	+	+	+	+	+	+	+	+	+		+	+	+		+	+
Nebraska	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	
Nevada	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
New Hampshire	+	+	+	+	+	+	+		+	+	+		+	+	+	●	
New Jersey	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●	●
New Mexico	●	●	●	●	●	●	●		●	●			●	●		●	
New York	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
North Carolina		+	+	+				+	+	+	+	+	+	+	+	+	+
North Dakota	+	+	+	+	+	+	+	+	+	+	+		+	+	+	+	+
Ohio	●	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●
Oklahoma			+	+					+	+						+	+
Oregon	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Pennsylvania	+	●	●	+	●			+	+	●	+	+	+	+		+	●
Puerto Rico	+	+	+			+						+	+		+		
Rhode Island		+	+	+	+			+	+	+						●	
South Carolina	●	●	●	●	●	●		●	●	●	●	●	●	●		●	●
South Dakota	●	●	●	●	●	●			●	●	●		●	+		+	
Tennessee	+	+	+		+			●				+	+			●	
Texas	●	●		●				●	●	●		●			●	●	
Utah	+	+	+	+	+	+	+	+	+	+	+		+	+		+	+
Vermont	+	+			+			+		+			+	+		+	+
Virgin Islands		+	+	+	+								+				
Virginia	+	+		+	+	+		+	+	+		+	+	+		+	
Washington	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
West Virginia		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Wisconsin	+	+	+	●	●	+	+	+	●	+	●		+	+	●	+	+
Wyoming						●								●		●	

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¹*Basic required Medicaid services:* State Medicaid programs are required by Federal law and regulations to offer the following basic medical services to persons receiving Federally supported financial assistance, i.e., the categorically needy: inpatient and outpatient hospital services; other laboratory and X-ray services; skilled nursing facility services for persons 21 or older; early and periodic screening, and diagnosis of persons under 21 to determine their physical and mental defects, and treatment of conditions found; family planning services (effective 1/1/73); and physicians' services. In addition, home health services must be provided to any eligible person who is entitled to skilled nursing facility services, and State Medicaid plans must assure transportation of recipients to and from providers of services. If Medicaid is extended to cover the medically needy, i.e., individuals who would be categorically needy except for their higher income, Medicaid must provide for them either the same basic services that are required for the categorically needy or a combination of seven services.

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Appendix B provides state-specific Medicaid data regarding client, provider, and service eligibility criteria as well as the identification of the relevant state authority. This information will assist you in determining whether Medicaid may be a potential third party source for your program. However, before making a final decision, it will be necessary for you to obtain specific details regarding eligibility determination and operating procedures from either your SSA or state Medicaid authority.

Obtaining Provider Status

Participation in the Medicaid program requires that a provider be certified by the state Medicaid authority as meeting its eligibility criteria; there must be a formal agreement between the provider and the Medicaid authority. A suggested procedure for pursuing Medicaid certification is outlined below:

1. Contact the state's Medicaid authority to obtain its requirements and application form for participation.

2. Review the requirements for participation and determine if your program meets all mandatory requirements. Note: Some requirements might be specified as "should" or "desirable" as opposed to "must." Although they are probably not mandatory, meeting these requirements increases the likelihood of certification; they should be met if possible. However, since some states are fairly lenient with respect to optional requirements, you should contact the Medicaid authority to determine their importance in your state.

3. If your program does not currently meet all the mandatory requirements, you must decide whether to make the necessary changes to meet these, or abandon Medicaid certification.

4. The next step, if you are pursuing Medicaid certification and believe that you meet the state's requirements, is to complete the application and submit it, along with any other required materials, to the Medicaid authority.

5. The Medicaid authority will then review your application. If it is acceptable, an on-site inspection of your facility may be made to verify that it complies with state regulations.

6. If your application is rejected or your facility does not pass the on-site inspection, you will be notified; the shortcomings will be identified. You will have an opportunity to take the necessary actions and reapply. There is also an appeal mechanism if you wish to protest the rejection.

7. If your program is certified for participation, you will have to enter into a formal agreement with the state Medicaid authority. This agreement varies from state to state, but generally includes conditions relating to maximum charge for services, willingness to abide by the Medicaid regulations, and accessibility of financial and other records.

Reimbursement

States are required to set maximum limits on reimbursement for each type of service covered. Thus, a provider cannot be reimbursed more than the upper limit, but may receive less depending on the basis for reimbursement and/or the actual cost to the provider. Medicaid regulations stipulate that hospitals be reimbursed for inpatient care on the basis of "reasonable cost." Other service providers may be reimbursed according to state policies. However, federal regulations recommend that reimbursement be based on reasonable cost and stipulate that customary charges serve as the basis for determining the upper limit of payment for various types of services. Generally, the upper limits are established on the basis of "reasonable cost" or "reasonable charge."

- Reasonable cost: The actual cost of providing a service. However, the cost must be in line with costs of similar providers in the same locality for the same service.

- Reasonable charge: Generally based on "customary charges" or "prevailing charges."

Customary charge: The charge that a particular provider usually makes for a given service. If no one amount is charged to the majority (75 percent - 80 percent) of clients, the median charge is normally used.

Prevailing charge: A charge that lies within the range of charges that are most common within an area (i.e., a political or economic subdivision of a state).

Some states, however, have established a flat rate for specific services; this rate applies to all providers on a statewide basis.

TITLE XX: GRANTS TO STATES FOR SERVICES

Background

Title XX of the Social Security Act (officially known as Grants to States for Services), part of the Social Security Amendments of 1974, became effective on October 1, 1975. Title XX supersedes title VI (Services to the Aged, Blind, and Disabled) and that portion of title IV-A (Aid to Families with Dependent Children /AFDC7) dealing with services to eligible individuals.

The purpose of title XX is to establish a consolidated program for federal assistance that will encourage states to provide social and rehabilitative services to help low-income individuals and families obtain employment, achieve self-care, and attain family stability by providing services directed to the following goals:

1. To achieve or maintain economic self-support to prevent, reduce, or eliminate dependency

2. To achieve or maintain self-sufficiency, including reduction or prevention of dependency

3. To prevent or remedy neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserve, rehabilitate, or reunite families

4. To prevent or reduce inappropriate institutional care by providing for community-based care or other forms of less intensive care

5. To secure referral or admission for institutional care when other forms of care are not appropriate, or provide services to individuals in institutions.

Thus, title XX emphasizes the provision of social and rehabilitative services to eligible individuals, in contrast with the Medicaid and Medicare programs, which emphasize medical services. Title XX, in fact, specifically precludes services that are available to an individual under the state's Medicaid program.

The title XX program is administered at the federal level by the Social and Rehabilitation Service of the Department of Health, Education, and Welfare and at the state level by a Single State Agency established for that purpose. (This is the same agency that administers title IV-B [child welfare], IV-C [work incentive program], and IV-D [child support and paternity establishment]). Under title XX federal support is at the rate of 75 percent (except for family planning services, which receive a 90 percent match). Within the maximum of $2.5 billion per year, funds are allocated to the states on the basis of population. Note: This has been the ceiling for federal social services funding since 1972. Thus, title XX does not represent a source of additional funds. This is important, as many states are currently expending all or nearly all of their federal social service dollars and, as a result, are not likely to support new services.

Title XX regulations require that at least 50 percent of the federal share be used to provide services to individuals eligible for Medicaid; to those individuals receiving, or eligible to receive, cash payments under Aid to Families with Dependent Children (AFDC), Supplemental Security Income for the Aged, Blind, and Disabled (SSI), or state supplementary payments; or to individuals whose financial status is taken into account in determining assistance to these groups. Title XX represents a major change in the nature of federal assistance to states for the provision of social services. Previously, federal support was in a form referred to as "categorical assistance," as federal funds could only be used to assist specified categories of individuals (most typically the aged, blind, and disabled). Title XX, on the other hand, permits states considerable latitude in determining:

- What services will be made available. Basically, the only requirement is that each service offered be directed at one of the five program goals of title XX.

- Which people will be eligible for services. A state may offer one or more services to anyone who receives cash payments under AFDC or SSI or has an income that does not exceed 115 percent of a state's median income as adjusted for family size.

- Where and how services will be provided. Different services may be made available in different geographic areas within the state.

Public Participation

A major objective of title XX is to give states the opportunity to make their social services programs fit the needs of people in the state and local communities. To accomplish this, a major change has been made in the planning process.

Under title XX, a state's services plan will be subject to review by the state's citizens, initially and each time a new plan is prepared. To assure that citizens have an opportunity to review and comment on the services program, the state's title XX agency must develop a Comprehensive Annual Services Program Plan (CASPP) and make it public at least 90 days prior to implementation. A minimum of 45 days must be allowed for public comment. The final plan (noting any differences between it and the proposed plan and the reasons for such differences) must be published at least 45 days after publication of the proposed plan, and prior to implementation.

The CASPP must state:

- What the state hopes to achieve by providing services
- Which people are eligible to receive which services
- Which services will be provided in each geographic area
- Estimated expenditures for each service, category of recipient, and geographic area
- Information about program administration, use of public and private agencies and volunteers, and where people can apply for services

In addition, the description of the service plan must meet the following criteria:

1. Each service offered must be described as a separately identifiable service. In other words, broad categories such as "drug abuse services" would not be adequate; rather, the CASPP must specify "methadone maintenance," "residential care," "detoxification," and so on. However, it should be noted that drug abusers may be eligible to receive services under one or more of the other specified service categories (e.g., counseling).

2. Each service must be described as to the method of delivery. Services can be provided by the state in one of three ways:

    - Directly, through state-operated clinics or institutions maintained by the title XX agency

    - By contract (formal or informal non-monetary agreements) with other state and local government agencies

    - Under purchase of services agreement with independent (public and private) providers

Generally, medical and remedial care services are not covered under title XX, which supports social services. However, medical and remedial care services can be covered if they meet the following requirements.

- They must constitute an integral but subordinate part of a service described in the plan (i.e., the particular service cannot be provided without the essential medical or remedial care).

- They must not exceed 25 percent of the total reimbursement for the service of which the medical and remedial care is a part.

- They must not be available to the individual under the Medicaid program in the state.

- They must be explicitly identified in the definition of the service of which they are a part.

For room and board services to be covered under the plan, they must constitute an integral but subordinate part of the service and be limited by the following:

- They must not exceed 25 percent of the total amount for which reimbursement is made if room only, or board only, is provided.
- They must not exceed 40 percent of the total amount for which reimbursement is made if both room and board are provided.

In addition, the CASPP must specifically identify room and board as a component of the service plan.

Information regarding the CASPP and/or the review process in your state may be obtained by contacting the state title XX agency. The name and address of the title XX agency in your state is given in Appendix C.

Services Covered

The title XX regulations mandate:

- At least three services for SSI recipients
- At least one service directed at each of the five title XX program goals

Additionally, states are required to provide:*

- Family planning services for AFDC recipients
- Foster care services, if the state has an AFDC program

Other services may be included at the state's option providing they are consistent with title XX goals. Services that might be covered would include child care, counseling, staff training and employment-related services, health support services, information and referral activities, and particular combinations of services directed at "the special needs of children, the aged, the mentally retarded, the blind, the emotionally disturbed, the physically handicapped, alcoholics, and drug addicts." Thus, services for drug addicts may be specifically included in a state plan or some of the services provided by a drug abuse treatment program may be included in the type of services covered (e.g., health support or employment services). Note also that title XX permits the use of funds for staff training activities. Thus, a program may be able to recover all or part of the costs incurred for this purpose.

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*Failure to provide these services will result in a reduction in federal support for the state's AFDC program.

Because state plans vary, it is beyond the scope of this course to identify the specific services covered in each state. Therefore, you should contact your SSA or state title XX agency for the information necessary to help you determine whether or not title XX in your state is a likely source of funds for your program. However, the information in the state title XX charts in Appendix C may be helpful in making a preliminary determination.

Client Eligibility

Client eligibility for title XX services is limited to low-income individuals. To be eligible, individuals must either be categorically needy (classified as "income maintenance status") or meet an income test (classified as "income status").

Income Maintenance Status

Individuals are eligible under this classification if they meet one of the following categorical requirements:

- AFDC recipients
- Persons whose needs were considered in determining the needs of an AFDC recipient
- SSI recipients
- Recipients of state supplementary payments

Income Status

Individuals whose family's gross income is less than 115 percent (or, at state option, a lower percentage) of the median income of a family of four in the state, adjusted for size of family qualify in this category.

Within these two general categories, states have considerable freedom in setting eligibility criteria. For example:

- The upper limit for income eligibility can be set at any figure *below* the 115 percent level.
- Income limits can be different for different services.
- Income limits can be different for different categories of individuals.
- Eligibility for a particular service can be limited to a specific category of eligible individuals.

Individuals in the "income status" category may be charged a fee, depending on their income level.* Specifically, a fee *must* be charged if the family income falls between 80 percent and 115 percent of the adjusted median income for a family of four. A fee *may* be charged individuals whose family income is less than 80 percent of the adjusted level for a family of four. This specification is shown in Figure 4-1. Such fees *may* also be charged to individuals in the "income maintenance status." Where such fees are imposed, they must be "reasonable" and "income related." This means that states imposing a fee must establish some type of sliding fee schedule in order to ensure that otherwise eligible individuals are not denied services due to their inability to pay for such services. (See Table 4.3).

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*"Income" means the monthly total of all sources of income including wages, salary, self-employment income, dividends, interest, rental income, royalties, pensions, annuities, alimony, child support, unemployment compensation, workmen's compensation, public assistance or welfare payments, all Social Security payments, including railroad retirement, and veteran's pensions. It does *not* include money obtained through illegal activities.

Table 4.3

Median, 80 Percent, and 115 Percent Income Levels for Families of Four, by State
(Effective from October 1, 1975 to September 30, 1976)

State	Median	80% Level	115% Level
Alabama	$11,790	$ 9,432	$13,559
Alaska	17,223	13,778	19,806
Arizona	13,917	11,134	16,005
Arkansas	11,195	8,956	12,874
California	14,778	11,822	16,995
Colorado	14,178	11,342	16,305
Connecticut	15,404	12,323	17,715
Delaware	14,114	11,291	16,231
District of Columbia	13,599	10,879	15,639
Florida	13,427	10,742	15,441
Georgia	12,738	10,190	14,649
Hawaii	15,688	12,550	18,041
Idaho	12,605	10,084	14,496
Illinois	15,152	12,122	17,425
Indiana	14,004	11,203	16,105
Iowa	14,242	11,394	16,378
Kansas	13,758	11,006	15,822
Kentucky	11,430	9,144	13,145
Louisiana	11,430	9,144	13,145
Maine	11,330	9,064	13,030
Maryland	15,441	12,353	17,757
Massachusetts	14,393	11,514	16,552
Michigan	15,302	12,242	17,597
Minnesota	14,911	11,929	17,148
Mississippi	10,830	8,664	12,455
Missouri	$13,319	$10,655	$15,317
Montana	12,848	10,278	14,775
Nebraska	13,280	10,624	15,272
Nevada	14,803	11,842	17,023
New Hampshire	13,458	10,766	15,477
New Jersey	15,744	12,595	18,106
New Mexico	11,436	9,149	13,151
New York	14,264	11,411	16,404
North Carolina	12,163	9,730	13,987
North Dakota	14,746	11,797	16,958
Ohio	14,048	11,238	16,155
Oklahoma	12,095	9,676	13,909
Oregon	13,787	11,030	15,855
Pennsylvania	13,374	10,699	15,380
Rhode Island	13,208	10,566	15,189
South Carolina	11,799	9,439	13,569
South Dakota	12,701	10,161	14,606
Tennessee	11,591	9,273	13,330
Texas	12,957	10,366	14,901
Utah	12,843	10,274	14,769
Vermont	12,007	9,606	13,808
Virginia	13,784	11,027	15,852
Washington	14,035	11,228	16,140
West Virginia	11,443	9,154	13,159
Wisconsin	14,024	11,219	16,128
Wyoming	12,916	10,333	14,853

Source: Social and Rehabilitation Service

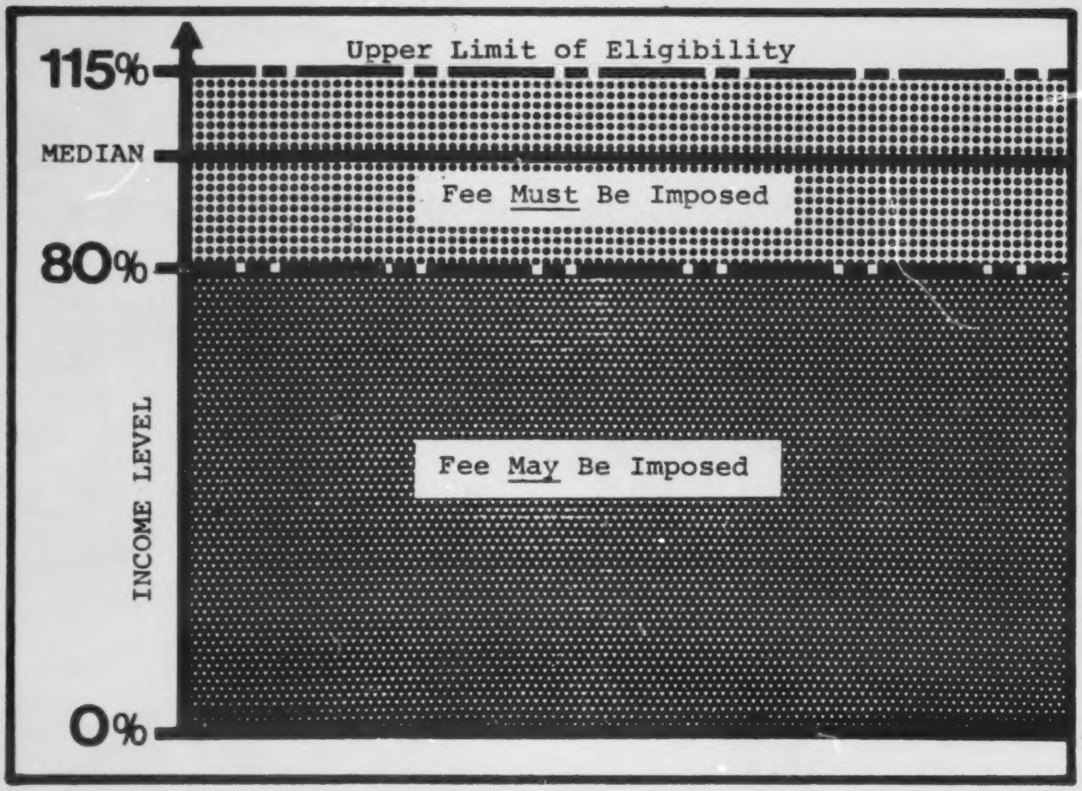


Figure 4.1 Relationship between Income Level and Fee-for-Service Requirement of title XX. (Source: National Clearinghouse for Drug Abuse Information, Report Series 35, Issue A.)

A chart for adjusting various family sizes to an equivalent income ceiling for a family of four is shown below:

Number of Family Members	Equivalent Income Ceiling (Percentage of Median for Family of 4)
1	52%
2	68%
3	84%
4	100%
5	116%
6	132%

For each additional family member, add 3 percentage points to the percentage for a family of six.

Determination of client eligibility may be made either by the state title XX agency or, at the state's option, by the provider (as a result of contractually delegated authority). Eligibility determination, whether by the state or the provider, normally cannot be made solely on the basis of statements made by the individual, except in cases where documentation is clearly unobtainable. In the latter case a sworn affidavit that has been witnessed and signed may be acceptable. Support, such as verification of income maintenance payments from the appropriate agency (income maintenance status) or paycheck stubs (income status), generally must be provided by the applicant.

Provider Eligibility

Specific requirements for provider eligibility are established by the state, and, therefore, vary considerably. Generally, requirements relate to administrative management, quality of care, delineation of services, and extent and nature of services provided.

Federal regulations require a written contract, called a *Purchase of Services Agreement (PSA)*, between the provider and the state agency. The PSA must:

- Specify a start and termination date

- Contain a detailed description of the services to be provided (including type and number of units)
- Specify the basis for, and nature of, the reimbursement procedure
- Specify the location where the services are to be performed
- Guarantee the confidentiality of client information
- Assure compliance with the Civil Rights Act of 1964
- Specify requirements for financial management (e.g., record keeping, fiscal controls, reporting and monitoring procedures)
- Provide for review of program records by state and federal officials
- Comply with other specific terms and conditions relating to the provision of services

Additionally, a program must meet the specific title XX eligibility requirements established by the welfare department of the state in which it operates.

Provider status for title XX is established with the state or local social service agency through negotiation of a Purchase of Services Agreement. *The specific terms and conditions of such an agreement and the nature of the negotiation process will vary considerably from state to state.* The specific requirements for a provider must, therefore, be obtained by contacting the title XX agency in your state. The identity of these agencies, together with some state-specific data regarding title XX plans, may be found in Appendix C.

Reimbursement

The specific procedure for receiving reimbursement from title XX will vary from state to state. However, a common procedure is for payments to be generated by individual programs, as a result of providing eligible services to eligible clients, and for reimbursement to be made by the state's title XX office to an agency (e.g., Single State Agency) that actually holds the Purchase of Service Agreement and has some type of relationship and agreement with the specific providers.

The latter agency thus functions as an intermediary between the provider and the payer. Where such an arrangement exists, the intermediary may select the basis upon which payments are allocated or distributed to the various programs providing the services. Thus, in such a case, the monies received by a provider will not necessarily be directly related to the nature and/or extent of services actually provided to eligible clients. This type of situation is diagrammed in Figure 4.2.

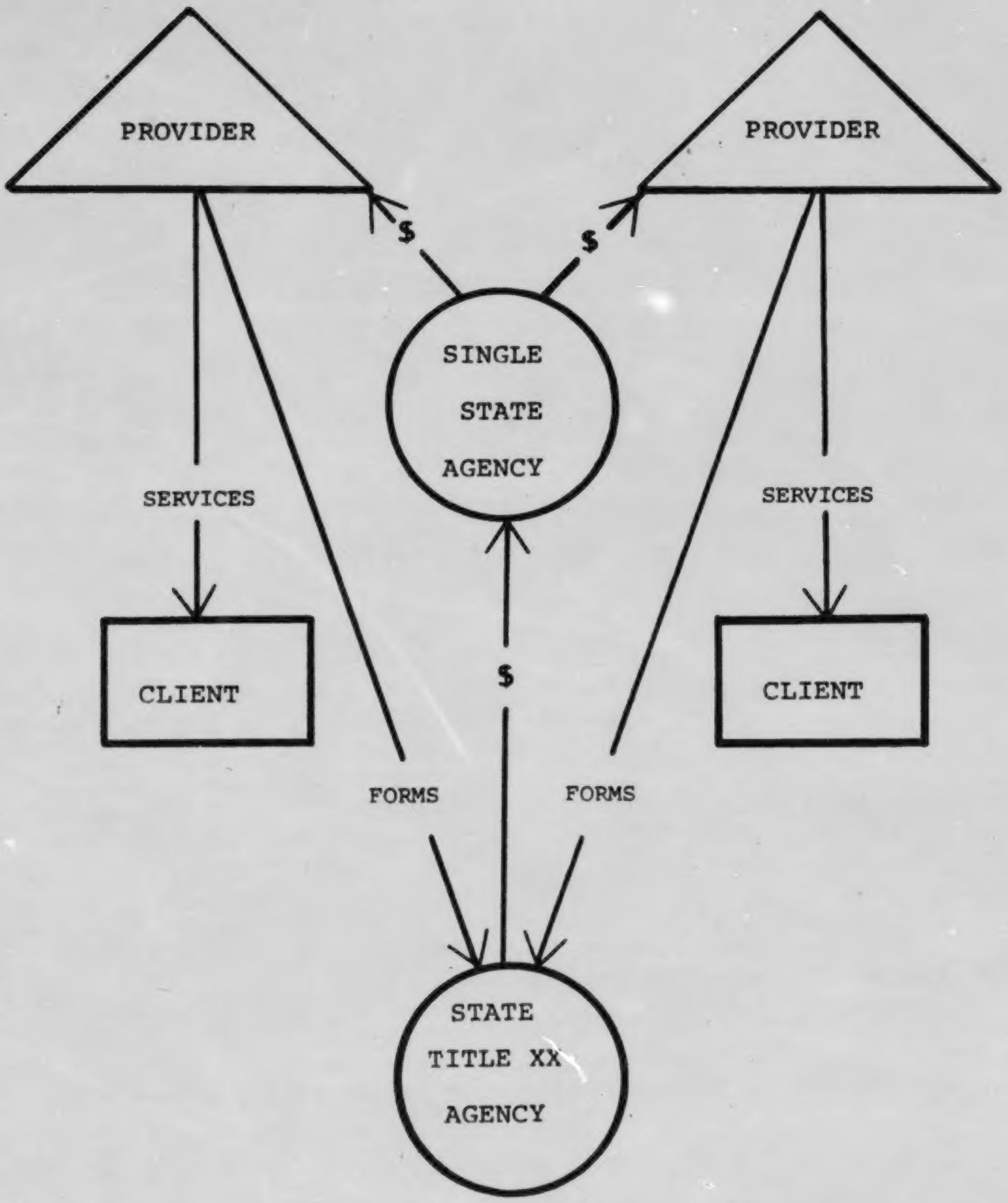
MEDICARE

Medicare (officially known as title XVIII of the Social Security Act -- Health Insurance for the Aged and Disabled) is a major medical insurance plan for eligible individuals who are at least 65 years old or disabled. The program is administered by the Bureau of Health Insurance (BHI) of the Social Security Administration. BHI negotiates and administers agreements with (1) service providers, (2) state agencies responsible for certifying service providers, and (3) intermediaries and carriers responsible for making payments, conducting audits, etc. Medicare is a federal program and, therefore, eligibility and coverage are uniform nationwide.

Medicare is, in fact, two separate and distinct programs. The two programs differ with respect to type of benefits, method of financing, nature of participation by beneficiaries, and the legal basis for their operation. These two programs are generally designated by sections of title XVIII from which they originate -- Part A and Part B. Part A (Hospital Insurance Benefits for the Aged and Disabled) covers hospital and post-hospital services. Part B (Supplementary Medical Insurance Benefits for the Aged and Disabled) covers physicians' services and various outpatient services. Part A is financed by compulsory contributions of employees and employers through the payroll tax, while Part B is a voluntary program financed in equal amounts from premiums paid by the insured and a contribution from general fund revenues. Part A interacts with Medicaid in that, if the recipient is eligible for Medicaid and the services are covered, Medicaid can pay for services that are not covered by Medicare.

Services Covered Part A

The services covered under Medicare Part A fall into three broad categories: inpatient hospital services, post-hospital extended care, and home health services. Several specific services are


PROVIDER
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SERVICES
CLIENT
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FORMS
STATE
TITLE XX
AGENCY

Figure 4.2. Common Title XX Reimbursement Procedure

covered under each of these categories.

Inpatient Hospital Services

- Bed and board
- Nursing and related services
- Drugs, biologicals, supplies, appliances, and equipment
- Other diagnostic or therapeutic items or services ordinarily furnished to inpatients
- Services provided by interns or residents in training, if they are in an approved teaching program.

Inpatient hospital services are covered for a period of up to 90 days for each spell of illness. Also, each patient is entitled to an additional lifetime limit of 60 days of coverage for spells of illness exceeding 90 days. However, this "lifetime reserve" cannot be used for hospitalization in a psychiatric facility.

External Care Services

The following services are covered if provided by a "skilled nursing facility" to which an individual has been transferred following discharge from a hospital in which he was an inpatient for a minimum of three consecutive days:

- Bed and board
- Nursing care
- Physical, occupational, or speech therapy
- Certain medical social services
- Drugs, biologicals, supplies, appliances, and equipment
- Medical services of interns and residents in training, if they are in an approved teaching program
- Other health services generally provided by such a facility

Home Health Services

- Part-time, intermittent nursing care
- Physical, occupational, or speech therapy
- Medical social services under the direction of a physician
- Certain part-time or intermittent services of a home health aide
- Medical supplies, other than drugs and biologicals
- Medical services provided by an intern or resident in training
- Any of the above services provided on an outpatient basis at a hospital or skilled nursing facility when special equipment is required

Services Covered Part B

The services covered under Medicare Part B include, physicians' services, services and supplies related to physicians' services, outpatient services, and home health services.

Physicians' Services

The types of physicians' services covered are:

- Surgery
- Consultation
- Office visits
- Institutional visits
- Home visits

However, coverage for physicians' services rendered to individuals having a psychiatric diagnosis is limited to 50 percent of the charges unless the care is provided in a licensed general hospital.

Service and Supplies

Items covered are services of auxiliary personnel (e.g., nurses, therapists, technicians) and medical supplies (e.g., bandages, ointments, non-self-administered drugs) directly related to the services of a physician.

Outpaitent Services

This category includes diagnostic services, therapeutic services, and supplies related to such services.

Home Health Services

Part B covers the same home health services as covered by Part A; however, prior hospitalization is not required.

Client Eligibility Part A

There are three eligibility categories for Medicare Part A:

1. Individuals who have reached the age of 65 and are entitled to Social Security retirement or survivor benefits, or who qualify as railroad retirement beneficiaries

2. Individuals under 65 who have been entitled to Social Security payments because they have been disabled for 24 months (However, if the date of onset of the disability is determined to be within the past 12 months, the 24-month requirement is reduced by the number of months of prior entitlement.)

   (Individuals falling into one of the above categories receive coverage without charge.)

3. Individuals who have elected to enroll in Part B, but are not otherwise eligible for Part A, may purchase Part A coverage by paying a monthly premium.

Client Eligibility Part B

This is a voluntary program requiring the payment of a monthly premium. There are two eligibility categories:

1. Individuals eligible for Part A are automatically enrolled in (and billed for) Part B unless they decline in writing.

2. Individuals not eligible for Part A who have reached the age of 65 and are U.S. residents (either U.S. citizens or aliens lawfully admitted for permanent residence who have resided in the United States for five months preceding enrollment)

Additionally, state welfare departments may elect to "buy-in" to provide Part B coverage for eligible individuals who receive public assistance. In this case, the state pays the monthly premiums.

All Medicare beneficiaries receive an identification card. Eligibility of a particular individual for Medicare can be determined by contacting the district office of the Social Security Administration or the responsible state agency (see Table 4.4). Note, however, that such contacts are subject to the confidentiality regulations discussed in Section 5.

Provider Eligibility

Eligible providers under Part A (formally designated "providers of services") are limited to:

- Hospitals
- Skilled nursing facilities
- Home health agencies
- Clinics, rehabilitation agencies and public health agencies (for outpatient physical therapy or speech pathology services only)

Eligible providers under Part B (formally designated "suppliers of services") are:

- Physicians
- Suppliers of medical and other health services
- Suppliers of drugs and biologicals
- Independent laboratories

Eligibility for participation in the Medicare program requires that the "providers" and "suppliers" (other than physicians) comply with the statutory requirements of title XVIII and with requirements established by HEW (relating to the health and safety of patients).*

Certification that a provider (or supplier) complies with the conditions of participation (or coverage) is made by the state agency responsible for Medicare, generally on the basis of an on-site inspection. Once certification has been obtained, a provider must enter into a formal agreement with HEW. A copy of this agreement is shown in Figure 4.3.

Physicians need not meet conditions of participation nor must they contract with the government. All physicians are eligible to provide services to beneficiaries as long as such services are within the scope of those permitted by their state license.

Reimbursement

Payment to institutional providers is made on the basis of "reasonable cost" (for both Part A and Part B). Reasonable cost is the actual cost to the provider of furnishing a service. Reimbursement is made on the basis of an estimated interim rate agreed to by the provider and the state agency. This rate is subject to an annual retroactive adjustment reflecting the costs actually incurred, as detailed in the annual cost report prepared by the provider.

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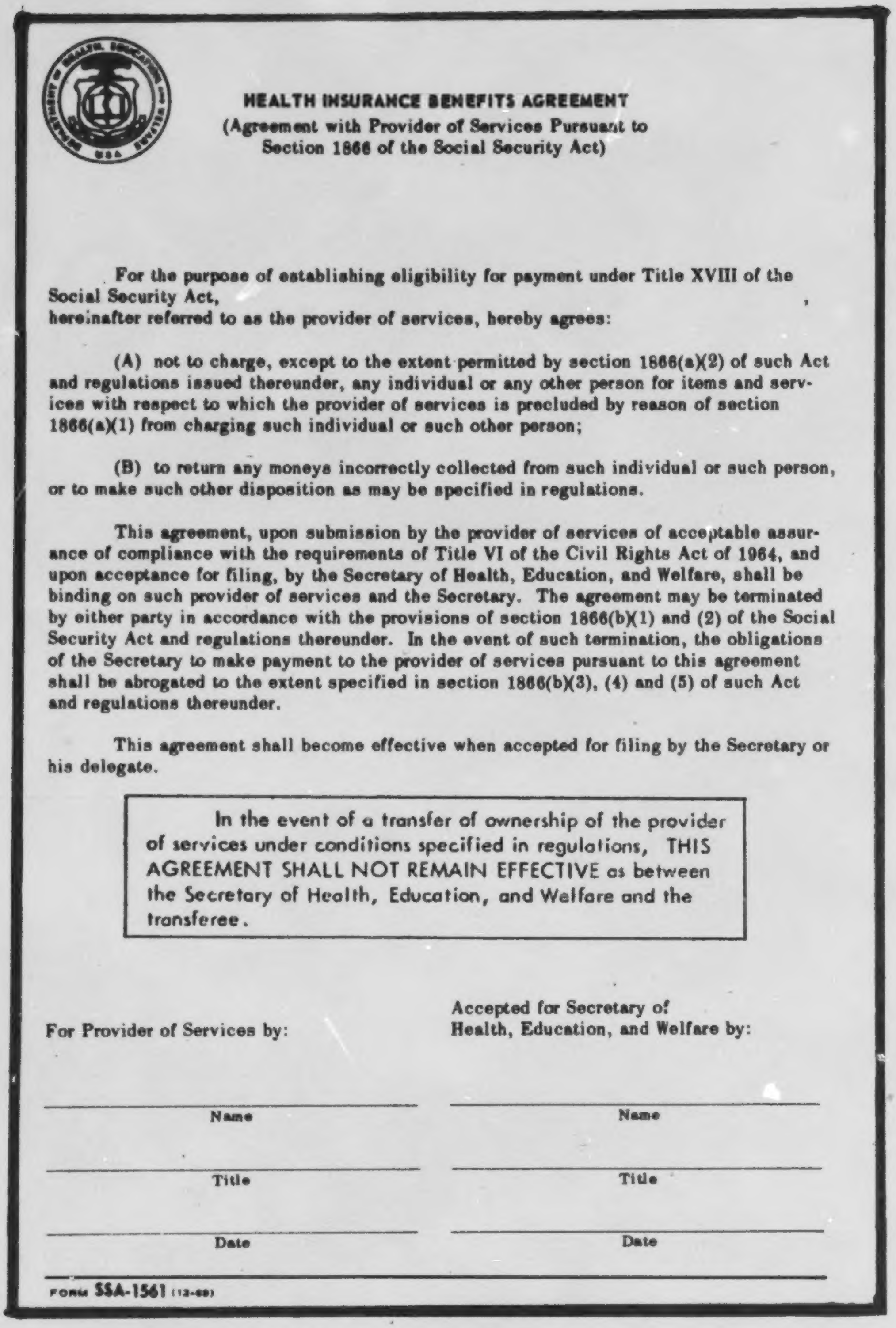
* These requirements, taken together, are referred to as "Conditions of Participation" (when referring to providers of services, and have been specifically developed for each provider category) and as "Conditions for Coverage" (when referring to suppliers of services, other than physicians).

Reimbursement to a physician is made on the basis of "reasonable charge." A reasonable charge is one that is no higher than (a) the physician's customary charge for a particular service, (b) the prevailing charge for that service by other physicians in the area, and (c) the actual charge made by the physician.

The following example (taken from the Part B Intermediary Manual) shows how these factors interrelate:

> The prevailing charge recognized by Medicare for a specific medical procedure ranges from $80 to $100 in a certain locality.
>
> Doctor A's bill is for $75, although he customarily charges $80 for the procedure.
>
> Doctor B's bill is for his customary charge of $85.
>
> Doctor C's bill is his customery charge of $125.00
>
> Doctor D's bill is for $100, although he customarily charges $80, and there are no special circumstances in the case.
>
> The reasonable charge for Doctor A would be limited to $75 since under the law the reasonable charge cannot exceed the actual charge, even if it is lower than his customary charge and below the prevailing charges for that locality.
>
> The reasonable charge for Doctor B would be $85, because it is his customary charge and it falls within the range of prevailing charges for that locality.
>
> The reasonable charge for Doctor C could not be more than $100, the top of the range of prevailing charges.
>
> The reasonable charge for Doctor D would be $80, because that is his customary charge. Even though his actual charge of $100 falls within the range of prevailing charges, the reasonable charge cannot exceed his customary charge in the absence of any special circumstances.



HEALTH INSURANCE BENEFITS AGREEMENT
(Agreement with Provider of Services Pursuant to
Section 1866 of the Social Security Act)

For the purpose of establishing eligibility for payment under Title XVIII of the Social Security Act, ,
hereinafter referred to as the provider of services, hereby agrees:

(A) not to charge, except to the extent permitted by section 1866(a)(2) of such Act and regulations issued thereunder, any individual or any other person for items and services with respect to which the provider of services is precluded by reason of section 1866(a)(1) from charging such individual or such other person;

(B) to return any moneys incorrectly collected from such individual or such person, or to make such other disposition as may be specified in regulations.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with the requirements of Title VI of the Civil Rights Act of 1964, and upon acceptance for filing, by the Secretary of Health, Education, and Welfare, shall be binding on such provider of services and the Secretary. The agreement may be terminated by either party in accordance with the provisions of section 1866(b)(1) and (2) of the Social Security Act and regulations thereunder. In the event of such termination, the obligations of the Secretary to make payment to the provider of services pursuant to this agreement shall be abrogated to the extent specified in section 1866(b)(3), (4) and (5) of such Act and regulations thereunder.

This agreement shall become effective when accepted for filing by the Secretary or his delegate.

In the event of a transfer of ownership of the provider of services under conditions specified in regulations, THIS AGREEMENT SHALL NOT REMAIN EFFECTIVE as between the Secretary of Health, Education, and Welfare and the transferee.

For Provider of Services by:	Accepted for Secretary of Health, Education, and Welfare by:
Name	Name
Title	Title
Date	Date

FORM SSA-1561 (12-66)

Figure 4.3. Agreement with Provider of Services for Participation in Medicare.

Table 4.4

STATE AGENCIES RESPONSIBLE FOR MEDICARE

ARIZONA: State Department of Health, Phoenix, AZ

ARKANSAS: State Department of Health, Little Rock, AR

CALIFORNIA: State Department of Public Health, Sacramento, CA

COLORADO: Department of Health, Denver, CO

CONNECTICUT: State Department of Health, Hartford, CN

DELAWARE: Department of Health and Social Services, Dover, DE

DISTRICT OF COLUMBIA: District of Columbia Department of Human Resources, Washington, D. C.

FLORIDA: Department of Health and Rehabilitative Services, Jacksonville, FL

GEORGIA: Georgia Department of Human Resources, Atlanta, GA

GUAM: Department of Public Health and Social Services, Agana, Guam.

HAWAII: State Department of Health, Honolulu, HI

IDAHO: Department of Environmental and Community Services, Boise, ID

ILLINOIS: Illinois Department of Public Health, Springfield, IL

INDIANA: State Board of Health, Indianapolis, IN

IOWA: State Department of Health, Des Moines, IA

KANSAS: State Department of Health, Topeka, KA

KENTUCKY: Commonwealth of Kentucky State Department of Health, Frankfort, KY

LOUISIANA: Louisiana Health and Social Rehabilitation Services Administration, Baton Rouge, LA

MAINE: Maine Department of Health and Welfare, Augusta, ME

MARYLAND: Maryland State Department of Health and Mental Hygiene, Baltimore, MD

MASSACHUSETTS: Massachusetts Department of Public Health, Boston, MA

MICHIGAN: Michigan Department of Public Health, Lansing, MI

MINNESOTA: State Department of Health, Minneapolis, MN

MISSISSIPPI: Mississippi State Board of Health, Jackson, MS

MISSOURI: State Division of Health, Jefferson City, MO

MONTANA: Department of Health and Environmental Sciences, Helena, MT

NEBRASKA: State Department of Health, Lincoln, NE

NEVADA: State Department of Human Resources, Carson City, NV

NEW HAMPSHIRE: New Hampshire Division of Public Health, Concord, NH

NEW JERSEY: State Department of Health, Trenton, NJ

NEW MEXICO: New Mexico Health and Social Services Department, Santa Fe., NM

NEW YORK: New York State Department of Health, Albany, NY

NORTH CAROLINA: Department of Human Resources, Raleigh, NC

NORTH DAKOTA: State Department of Health, Bismarck, ND

OHIO: Ohio Department of Health, Columbus, OH

OKLAHOMA: State Department of Health, Oklahoma City, OK

OREGON: Department of Human Resources, Portland, OR

PENNSYLVANIA: Department of Health, Harrisburg, PA

PUERTO RICO: Puerto Rico Department of Health, San Juan, P.R.

RHODE ISLAND: Rhode Island Department of Health, Providence, RI

SOUTH CAROLINA: State Board of Health, Columbia, SC

SOUTH DAKOTA: State Department of Health, Pierre, SD

TENNESSEE: Tennessee Department of Public Health, Nashville, TN

TEXAS: State Department of Health, Austin, TX

UTAH: Department of Social Services, Division of Health,
Salt Lake City, UT

VERMONT: Vermont Department of Health, Burlington, VT

VIRGIN ISLANDS: Territorial Department of Health, St. Thomas,
Virgin Islands.

VIRGINIA: State Department of Health, Richmond, VA

WASHINGTON: Department of Social and Health Services, Olympia, WA

WEST VIRGINIA: State Health Department, Charleston, WV

WISCONSIN: Department of Health and Social Services, Madison,
WI

WYOMING: State Department of Health and Social Services,
Cheyenne, WY

VOCATIONAL REHABILITATION

Vocational Rehabilitation (VR) is a national program that provides services and materials for the rehabilitation of those whose physical or mental disabilities inhibit their employment but who, as a result of VR services, can reasonably be expected to become gainfully employed. The program currently operates under the Rehabilitation Act of 1973.

VR funds are distributed through the Rehabilitation Services Administration of HEW to each state Vocational Rehabilitation agency on a formula grant basis. The state agency, in turn, reimburses those individuals and projects it judges most in need of VR services. Although the majority (75 percent) of program funds are federal, states have considerable autonomy in determining how they will be used.

Many state VR agencies offer services to drug addicts. However, the specific nature of services provided and the severity of addiction required for client eligibility varies widely from state to state. Additionally, service availability often varies within a given state on the basis of relative need. For example, services to addicts are more likely to be offered in a metropolitan area than in a rural one.

Services Covered

Covered services are broadly defined as any item or service considered necessary to render a handicapped individual employable. These may include, but are not limited to:

- Evaluation of rehabilitation potential
- Counseling, guidance, referral and placement services
- Vocational and other training services
- Physical and mental restoration services, including corrective surgery or therapeutic treatment for physical or mental conditions, hospitalization, provision of prosthetic devices and visual services, and diagnosis and treatment for mental and emotional disorders.
- Maintenance during rehabilitation

- Other services or devices related to an individual's employability such as sensory aids, occupational training, licenses, tools, and equipment

Client Eligibility

The 1973 Vocational Rehabilitation Act directed that state VR agencies emphasize services directed to the "severly disabled" and listed specific conditions that automatically fall into this category. Additionally, criteria were established by which an individual not falling into one of the defined categories could be classified as being severely disabled. Substance abuse is not included in the list of severely disabling conditions, however, an individual addict may meet the criteria as "severely disabled."

Provider Eligibility

Generally, a state rehabilitation agency works in conjunction with a drug abuse treatment program to provide additional services to the program's clients. For example, VR may offer employment counseling, skill training, and placement services to an individual who has been treated, or is currently being treated, by a drug program. In some cases, the state agency will place a VR counselor in the program on a full-time or part-time basis. Less frequently, VR will refer addicts to a drug treatment program for services and reimburse the program for such services. State VR agencies have shown some reluctance to expend their limited funds for services provided by another federally supported operation. This is especially true when such services are also made available to individuals without cost.

Establishing a working arrangement with VR normally involves the development of a cooperative agreement, which may or may not be formalized in writing, rather than a contractual arrangement such as required for Medicaid. An agreement of this type outlines the basis for a cooperative relationship between the treatment program and VR, indicating the type of services that will be provided by the respective organizations, at what stage in the treatment process referrals will be made, etc. Further details can be obtained from the local vocational rehabilitation agency in your state.

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS)

CHAMPUS provides comprehensive health care benefits to dependents of active duty Uniformed Services* members, retired members and their dependents, and surviving dependents.

CHAMPUS beneficiaries can obtain reimbursement for both inpatient and outpatient medical care and treatment from civilian medical sources under the basic program. In addition, there is a special program of generally nonmedical rehabilitative benefits for the seriously physically handicapped and moderately or severely mentally retarded spouses and children of active duty members of the Uniformed Services.

CHAMPUS does not process any claims itself. All claims are submitted to, and approved and paid by fiscal administrators, each having responsibility for a particular state (see Table 4.5 for a list of CHAMPUS fiscal administrators).

Client Eligibility

Individuals eligible for CHAMPUS benefits are:

- Spouses and children of members of the Uniformed Services who are serving on active duty (including active duty for training) under a call or order that does not specify a period of 30 days or less, and the surviving spouses and children of deceased active duty members
- Retired and former members of the Uniformed Services who are entitled to retired, retainer, or equivalent pay, and their spouses and children and the surviving spouses and children of such members

Any beneficiary (except an active duty dependent) who, at age 65, has earned and is entitled to hospital benefits under Social Security Medicare loses his CHAMPUS eligibility.

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*The Uniformed Services are the Army, Navy, Air Force, Marine Corps, Coast Guard, and the Commissioned Corps of the Public Health Service and of the National Oceanic and Atmospheric Administration.

Services Covered

In general, any procedures and types of care that are generally accepted as being part of good medical practice, regardless of whether furnished on an inpatient or outpatient basis (other than those specifically excluded by the authorizing legislation) are authorized CHAMPUS benefits.

The general types of conditions covered by CHAMPUS are:

- Medical or surgical conditions
- Nervous, mental, and emotional disorders
- Chronic conditions and diseases
- Contagious diseases

Virtually all services provided by a physician or by other medically related specialists (nurses, physical therapists, etc.) as ordered by a physician are covered (unless specifically excluded by the enabling legislation). Authorized services* of psychologists may be provided without a physician's order.

Further, benefits cover necessary supplies and drugs if administered by a civilian facility, a physician, or procured by the client from a pharmacy (if a prescription is required for their issuance).

Provider Eligibility

Inpatient Facilities

There are two primary eligibility criteria for an inpatient drug abuse treatment facility; these are:

- State licensure

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*Services approved by the fiscal administrator. However, psychologists must be licensed or certified, have a doctoral degree in clinical psychology, and have a minimum of two years of supervised experience in clinical psychology in a licensed hospital, a mental health center, or other appropriate clinical setting as determined by the Director of CHAMPUS.

- Supervision of the program and of client services by a licensed physician

Any inpatient facility wishing to obtain provider status must complete a questionnaire describing the organization and operation of the treatment facility. This questionnaire will be used by CHAMPUS in determining eligibility. If the facility is approved, both the provider and the relevant CHAMPUS fiscal administrator (FA) will be notified. Subsequently, the FA will make an on-site inspection to verify the information in the questionnaire. The specific services covered are determined by the FA and not by CHAMPUS. Therefore, it is important for an approved facility to contact the appropriate FA as soon as possible.

Inpatient facilities are reimbursed on a prevailing or reasonable charge basis. CHAMPUS reimburses the provider for 75 percent of the charge. The remaining portion must be paid by the client.

Outpatient Facilities

The fiscal administrator has full responsibility for approving all outpatient facilities. Therefore, any such facility seeking provider status from CHAMPUS should contact the appropriate FA to obtain the eligibility requirements that it must meet. A list of CHAMPUS fiscal administrators is given in Table 4.5.

Reimbursement

CHAMPUS uses a cost-sharing plan, whereby it pays a share of allowable charges for authorized health care. The customary charges made by the provider and prevailing charges in the community for similar care are considered in determining allowable charges. Unusual circumstances and extraordinary professional effort also are taken into account.

Provider participation requires acceptance of the government's payment plus the client cost-sharing portion (noted below) as payment in full for services provided.

Client Cost-Sharing Portion

Inpatient Care:

- Spouses or children of active duty members: client's share is $25 or $3.70 per day, whichever is greater.
- All others: client's share is 25 percent of the medical facility charges and professional fees.

The government's share is the balance of allowable charges.

Outpatient Care:

A beneficiary's share of authorized charges is the first $50 in a fiscal year (the deductible), plus a percentage of allowable charges above that amount. For a family of two or more beneficiaries filing claims, the maximum deductible in a fiscal year is $100.

- Spouses or children of active duty members: client's share after the $50 or $100 deductible is 20 percent. The government pays the balance of allowable charges.
- All others: client's share after the $50 or $100 deductible is 25 percent. The government pays the balance of allowable charges.

CHAMPUS Information

For further information on CHAMPUS write to:

Director
Attn: Chief, Health Resources Information Divisi
OCHAMPUS
Denver, Colorado 80240

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Table 4.5

CHAMPUS FISCAL ADMINISTRATORS

ALABAMA
Mutual of Omaha Insurance Company
3301 Dodge Street
Omaha, Nebraska 68131

ALASKA
Blue Cross, Washington-Alaska, Inc.
P. O. Box 327
Seattle, Washington 98111

ARIZONA
Arizona Blue Shield Medical Service
P. O. Box 13466
Phoenix, Arizona 85002

ARKANSAS
Arkansas Blue Cross & Blue Shield, Inc.
P. O. Box 1418
Little Rock, Arkansas 72203

CALIFORNIA
California Blue Shield
Post Office Box 7608
San Francisco, California 94120

COLORADO
Colorado Medical Service, Inc.
700 Broadway
Denver, Colorado 80203

CONNECTICUT
Connecticut General Life Ins. Co.
Hartford, Conn. 06115

DELAWARE
Blue Cross & Blue Shield of Delaware, Inc.
201 West 14th Street
Wilmington, Delaware 19899

DISTRICT OF COLUMBIA
(Includes Prince Georges & Montgomery Counties of Maryland, Arlington & Fairfax Counties of Virginia, & the Cities of Alexandria & Falls Church, VA)

Medical Service of the District of Columbia
550 - 12th Street, S.W.
Washington, D. C. 20024

FLORIDA
Blue Shield of Florida, Inc.
P. O. Box 1798
Jacksonville, Florida 32203

GEORGIA
Medical Association of Georgia
938 Peachtree Street, N.E.
Atlanta, Georgia 30309

HAWAII
Hawaii Medical Service Association
P. O. Box 860
Honolulu, Hawaii 96808

IDAHO
North Idaho District
Medical Service Bureau, Inc.
P. O. Box 1106
Lewiston, Maine 83501

ILLINOIS
Mutual of Omaha Insurance Company
3301 Dodge Street
Omaha, Nebraska 68131

INDIANA
Indiana State Medical Association
3935 North Meridian Street
Indianapolis, Indiana 46208

IOWA
Blue Shield of Iowa
Liberty Building
Des Moines, Iowa 50309

KANSAS
Kansas Blue Shield
P. O. Box 239
Topeka, Kansas 66601

KENTUCKY
Kentucky Physicians Mutual, Inc.
3101 Bardstown Road
Louisville, Kentucky 40205

LOUISIANA
Continental Service Life & Health Ins. Co.
P. O. Box 3397
Baton Rouge, La. 70821

MAINE
Maine Blue Cross and Blue Shield
110 Free Street
Portland, Maine 04101

MARYLAND
(Excludes Prince Georges & Montgomery Counties, which are served by the fiscal agent for District of Columbia)

Maryland Blue Shield, Inc.
700 East Joppa Road
Towson, Maryland 21204

MASSACHUSETTS
Blue Shield of Massachusetts,Inc.
P. O. Box 2194
Boston, Mass. 02111

MICHIGAN
Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226

MINNESOTA
Blue Cross & Blue Shield of Minnesota
2344 Nicollett Avenue
Minneapolis, Minn. 55404

Table 4.5 continued

MISSISSIPPI
Mississippi State Medical Assn.
735 Riverside Drive
Jackson, Miss. 39216

MISSOURI
Missouri Medical Service
5775 Campus Parkway
Hazlewood, Missouri 63042

MONTANA
Montana Physicians' Service
P. O. Box 1677
Helena, Montana 59601

NEBRASKA
Blue Shield of Nebraska
Box 3248
Omaha, Nebraska 68103

NEVADA
Nevada State Medical Association
3660 Baker Lane
Reno, Nevada 89502

NEW HAMPSHIRE
New Hampshire-Vermont Physician Service
#2 Pillsbury Street
Concord, New Hampshire 03301

NEW JERSEY
Medical-Surgical Plan of New Jersey
P. O. Box 262
Newark, New Jersey 07102

NEW MEXICO
New Mexico Blue Cross & Blue Shield, Inc.
12800 Indian School Road, N.E.
Albuquerque, New Mexico 87112

NEW YORK
Blue Cross & Blue Shield of Greater New York
2 Park Avenue
New York, New York 10016

NORTH CAROLINA
Blue Cross & Blue Shield of North Carolina
800 South Duke Street
Durham, North Carolina 27702

NORTH DAKOTA
Blue Shield of North Dakota
301 South 8th Street
Fargo, North Dakota 58102

OHIO
Mutual of Omaha Insurance Company
3301 Dodge Street
Omaha, Nebraska 68131

OKLAHOMA
Blue Cross & Blue Shield of Oklahoma
P. O. Box 1738
Tulsa, Oklahoma 74102

OREGON
Oregon Physicians' Service
P. O. Box 1071
Portland, Oregon 97207

PENNSYLVANIA
Medical Service Assn. of Pa.
Blue Shield Building
Camp Hill, PA 17011

RHODE ISLAND
Mutual of Omaha Insurance Co.
3301 Dodge St.
Omaha, Nebraska 68131

SOUTH CAROLINA
Mutual of Omaha Insurance Co.
3301 Dodge St.
Omaha, Nebraska 68131

SOUTH DAKOTA
South Dakota Medical Service, Inc.
711 N. Lake Ave.
Sioux Falls, S. D. 57104

TENNESSEE
Blue Cross, Blue Shield of Tenn.
801 Pine St.
Chattanooga, Tenn. 37402

TEXAS
Mutual of Omaha Insurance Co.
3301 Dodge St.
Omaha, Nebraska 68131

UTAH
Blue Shield of Utah
P. O. Box 270
Salt Lake City, Utah 84110

VERMONT
New Hampshire-Vermont Physicians' Service
#2 Pillsbury St.
Concord, NH 03301

VIRGINIA
(Excludes Arlington County, Fairfax County & Cities of Alexandria & Falls Church, which are served by the fiscal Agent for District of Columbia)

Blue Shield of Virginia
P. O. Box 27401
Richmond, Virginia 23279

WASHINGTON
Washington Physicians' Service
220 W. Harrison St.
Seattle, Wash. 98119

WEST VIRGINIA
Medical-Surgical Care, Inc.
Union Trust Building, Box 1948
Parkersburg, W. Va. 26101

WISCONSIN
Wisconsin Physicians' Service
P. O. Box 1787
Madison, Wisc. 53701

WYOMING
Wyoming Medical Service, Inc.
P. O. Box 2266
Cheyenne, Wyoming 82001

FOOD STAMPS

The Food Stamp Act of 1964 established a program whereby food purchases made in the normal fashion would be subsidized by federal and state governments. The aim of the program is to provide for improved nutrition in low-income households. Eligible households (a family or economic unit, including individuals living alone) can receive coupons through the welfare agency. Recipients pay a percentage of the coupons' face value and may then use them to buy food products at retail stores authorized to participate in the program. The sole criterion for eligibility is income level, provided that all able-bodied adults in the household, except students and those caring for dependent children or disabled adults, are employed or actively seeking employment.

Relevance to Drug Abuse Programs

Amendments to the Act make drug addicts eligible for stamps if they are participating in a treatment program and qualify on the basis of income.

There are three ways in which an addict may obtain benefits:

- A client in an outpatient treatment program, living alone or as a member of a household, may obtain and use food stamps for his household meals. Food stamps are obtained by the individual or household through normal welfare agency procedures.

- A client in a day-care treatment program, living alone or as a member of a household, may obtain food stamps and use them to pay for meals at the program (if the program normally charges its clients for such meals and is authorized to redeem the coupons) as well as for his own meals at home. Food stamps are obtained by the individual or household through normal welfare agency procedures. Programs desiring to participate in this manner must submit an application (Form FNS-252-2) to a field office of the Food and Nutrition Service of the U.S. Department of Agriculture.

- A client living in a residential treatment program may obtain food stamps jointly with the program, for the program to use in providing his meals. In this case the program functions as an "authorized representative" of the Food and Nutrition Service (FNS) and is entitled to receive stamps directly from the issuing agency. The stamps may then be redeemed at designated wholesalers and banks. To be eligible to participate in this way, the client and the program must make a joint application to the local welfare agency. If approved, the program will be issued an Authorization to Purchase (ATP) card and food stamp coupons that can be used to provide meals for that specific client.

A list of regional offices of the Food and Nutrition Service is given in Table 4.6.

The third category may be considered a form of third party payment since provision of food stamps offsets the cost of providing meals to the client. To receive food stamps, the county welfare agency must certify that both the client and the program are eligible. Clients must meet the standard eligibility criteria. Eligibility criteria for the program are: (1) it must have written approval as a treatment program by the Single State Agency; (2) it must be a private, nonprofit organization (separate treatment programs, or "units," within the same organization must apply separately); and (3) it cannot receive federally donated funds in duplication of the Food Stamp Program benefits.

For certification to receive food stamps, the program and its clients must apply to the county welfare agency. Each client applicant must be individually approved as eligible. For authorization to accept and redeem food stamps, the program must apply to a Food and Nutrition Service Field Office of the U.S. Department of Agriculture. Approval of all these applications will mean: (1) the client, in conjunction with the program, is certified to receive food stamps; and (2) the program is authorized to accept the stamps as payment for the meals it provides the client and redeem them at face value (as if it were a retail food store), through similarly authorized wholesalers (for goods or cash) and banks (for cash and credit).

A new food stamps bill is currently being debated in Congress. Although the exact final form of the new bill cannot be predicted, it seems likely that the provision permitting residential treatment facilities to use food stamps jointly with eligible clients will be retained but that it will not be possible to redeem them for cash or credit as an option to food.

Table 4.6

REGIONAL FOOD AND NUTRITION SERVICE OFFICES OF THE U.S. DEPARTMENT OF AGRICULTURE

Midwest

(Midwest: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, Wisconsin)
536 South Clark Street
Chicago, Illinois 60605
(312) 353-6664

Northeast

(Northeast: Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Puerto Rico, Rhode Island, Vermont, Virgin Islands, Virginia, West Virginia)
729 Alexander Road
Princeton, New Jersey 08540
(609) 452-1712

West Central

(West Central: Arizona (Navajo Nation only), Arkansas, Colorado, Louisiana, Montana, New Mexico, North Dakota, Oklahoma, South Dakota, Texas, Utah, Wyoming)
1100 Commerce Street, Room 5-D-22
Dallas, Texas 75202
(214) 749-2877

Western

(Western: Alaska, American Samoa, Arizona (except Navajo Nation), California, Guam, Hawaii, Idaho, Nevada, Oregon, Washington, Trust Territory of the Pacific Islands)
550 Kearny Street, Room 400
San Francisco, California 94108
(415) 556-4951

Southeast

(Southeast: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee)
1100 Spring Street, N.W., Room 200
Atlanta, Georgia 30309
(404) 526-5131

PRIVATE THIRD PARTY PAYERS

PRIVATE INSURANCE COMPANIES

Health policies are offered by virtually every type of insurance company -- life insurance, casualty, accident and sickness underwriters, and, of course, those formed specifically for the purpose of providing health coverage. Various types of coverage are also offered by unions, by companies formed to provide coverage for specific occupations, and by fraternal organizations.

Insurance companies are generally divided into two types: mutual companies (organized to provide coverage for members at cost), and stock companies (designed to make a profit).

Insurance policies may be issued by either type of company to both groups and individuals. Group policies are written to cover the employees of a firm or the members of an association. One policy is issued for all employees or members wishing coverage. Individual policies, on the other hand, are issued to one person or a family unit.

Private health insurance available at the present time tends to emphasize coverage for inpatient services and services provided by recognized medical practitioners such as physicians and psychiatrists.

Services Covered

Both individual and group policies can offer an enormous range of services. Some may cover only hospitalization, while others may cover doctor's fees, outpatient treatment, psychiatric care, pharmacy charges, or coverage against major disease or surgery. Specific coverage will vary with respect to the particular company writing the policy as well as with respect to the particular type of policy purchased. This is especially true of group policies, as the organization purchasing the policy has considerable latitude in specifying both the type of services to be covered and the extent to which they will be covered (e.g., full coverage or a dollar limit). Group policies, therefore, tend to be customized for the buyer. Thus, two individuals having group medical coverage written by the same insurance company but who are employed by different firms may have very different coverage. As an example, the Michigan Blue Cross/Blue Shield contract with the United Auto Workers specifically covers the treatment of substance abuse, but other policies written for other customers by this carrier do not include such coverage.

Variability in services covered relates to types of illnesses (e.g., drug addiction may or may not be included in the categories of illnesses covered) and to the specific conditions under which services are provided. Thus, even if drug addiction is included in the list of covered illnesses, a policy may impose specific conditions. Examples of such conditions are: (a) services must be provided by a licensed physician, (b) services must be provided under the direction of a licensed physician, (c) services must be provided to inpatients in an accredited facility. Additional restrictions may further limit services by such factors as length of time, number of encounters, and/or eligibility of dependents (e.g., "up to 18 unless a student").

Although the particular coverage provided and the specific terms and conditions affecting each coverage (e.g., dollar or durational limits) will vary from policy to policy, there are certain basic categories of coverage that are offered by most companies writing health insurance.

Hospitalization

This type of insurance (also referred to as "basic protection") covers care in a hospital for periods ranging from 30 to 365 days or longer, depending on the particular policy.

In general, these benefits help pay for two types of services:

1. Daily room and board in the hospital, routine nursing care and minor medical supplies

2. Other hospital services, such as laboratory tests and X-rays, anesthesia and its administration, use of operating room, drugs and medications, and local ambulance service (These services may be referred to as miscellaneous or ancillary expenses.)

Frequently the benefit of these additional services is expressed as being so many times the room and board benefit. For example, if the room and board benefit is $50 a day, the additional expense benefit may be ten times this amount, or $500.

Major Medical

This type of coverage provides protection against the costs of serious and prolonged illnesses. The maximum amount such a policy pays varies. Some pay up to $20,000; some up to $250,000;

some have no limit at all. A high-benefit policy is popularly known as "catastrophic coverage." Major medical benefits cover virtually every type of care and treatment prescribed by a physician, both in and out of the hospital, including:

- Hospital services
- Physician's treatment and specialist's consultation and care
- Surgery
- X-ray and laboratory services
- Anesthesia and its administration
- Private duty nursing
- Prescribed drugs and medicines

Both hospitalization and major medical insurance generally have a deductible amount that is paid by the insured or by the "Basic Protection" insurance before major medical benefits start. This can range from $50 to $1,000 or more, depending on the policy.

Hospital Indemnity

These policies reimburse the insured for the actual cost of the medical services received up to the dollar limit specified in the policy, less any deductible amount. Some insurance companies write medical coverage on a "valued" basis, whereby the insured receives a specified dollar amount for each day during which he is hospitalized up to a maximum number of days, irrespective of the costs actually incurred.

Additional terms and conditions generally used by private insurers that serve to limit reimbursement are:

> Coinsurance, in which the insurance company and the insured each pay a percentage of the cost of treatment. For example, under the terms of the policy, the insured service recipient may pay 20 percent and the insurance company 80 percent of the costs incurred.
>
> Deductible, which specifies an amount of covered expenses that must be incurred by the insured before benefits become payable by the insurer. For example, the insured may have to pay the first $100.

Client Eligibility

Coverage is dependent on the payment of premiums, either by the individual policyholder or the group policyholder.

Client eligibility is automatic in the case of a group policy (i.e., all members of the group must be covered by the underwriter). However, in the case of an individual, eligibility might be related to factors such as age, physical condition, or family medical history.

An important consideration in regard to private insurance coverage for drug addicts will be the individual's employment status. Since an addict is most likely to use his income to support his habit and provide for the basic necessities, he probably does not have medical insurance unless it is provided by his employer. Therefore, determination of the proportion of your client population that is employed is basic to assessing the likelihood of obtaining reimbursement from private carriers.

Provider Eligibility

Specific provider eligibility criteria will vary from carrier to carrier. However, an individual provider generally must be a "licensed practitioner" and an institutional provider must be state licensed, accredited by an organization specified by the carrier, or (in the absence of either of these) approved on the basis of company-specific standards. For example, the aforementioned Michigan Blue Cross/Blue Shield contract with the UAW requires that residential and outpatient substance abuse programs comply with the requirements that they--

> (1) be licensed by the Michigan Department of Health;
> (2) be accredited by the Joint Commission on Accreditation of Hospitals; and (3) are in compliance with Blue Cross and Blue Shield of Michigan's qualifications for approval.

In order to be approved as a provider by a private carrier, you will generally have to submit a formal application, together with any supporting material specified by that carrier. Note: Such approval must be obtained from each carrier and the specific requirements and procedures will vary with each carrier. Most typically, the information required relates to:

- Identification of the facility (name, address, phone, etc.)
- Type of credentialing already obtained
- Type of services provided
- Size and professional qualifications of staff
- Fee schedule
- Client population

Additionally, many carriers will require an on-site inspection by their representative.

Blue Cross and Blue Shield

Blue Cross and Blue Shield are a loosely knit group of private nonprofit insurance companies (formally referred to as "Plans"). Each plan is a separately administered, local organization authorized to use the Blue Cross or Blue Shield name and emblem. Although Blue Cross and Blue Shield are separate programs, each having its own national association, in most areas they cooperate closely with one another.

Blue Cross provides coverage for hospital expenses that include hospital room plus other related services such as laboratory, X-ray, medication, and operating room. Blue Shield covers such physician's services as office visits (if connected with a hospital-related admission), surgical fees, etc.

The various Blue Cross and Blue Shield Plans operate much the same as other private insurance companies. They have the same degree of inter-organizational variability with respect to services covered and criteria that determine client and provider eligibility. However, with respect to provider eligibility, nearly all require state licensure and/or accreditation by a recognized organization such as JCAH or American Osteopathic Association (AOA). Many also require a certificate of need from the local department of public health specifying that the provider is necessary in the community and not duplicating services offered by others.

A major distinction between Blue Cross and commercial insurance companies is in the nature of the benefits payments. Blue Cross plans provide "service benefits" as opposed to "indemnity" and "valued" benefits. Service benefits pay 100 percent of the costs of those services covered in this manner. Some services, however, are covered on a regular fee-schedule basis, whereby the insured is reimbursed for the cost of the service up to a fixed dollar limit.

Another distinction between Blue Cross and commercial carriers relates to the nature of the hospital-carrier relationship: a contractual relationship is generally established whereby the type of services to be covered on a service benefits basis, and the reimbursement for each, are agreed to by the respective parties.

Mandatory Coverage for Drug Addiction

In an attempt to ensure medical coverage for drug addiction on the part of private carriers, bills have been introduced in several state legislatures that would mandate the inclusion of some type of drug abuse treatment benefits in group health insurance policies offered in the state. As of April 1976, five states (Hawaii, Minnesota, Nevada, North Dakota, and Wisconsin) had enacted such legislation and it was pending in five others (Alaska, Arkansas [under study], Kansas, Michigan,* and South Dakota). The nature of the benefits required by states having this type of legislation is given in Table 4.7.

HEALTH MAINTENANCE ORGANIZATIONS

Health Maintenance Organizations (HMOs) are organized systems of health care that provide or otherwise assure the delivery of an agreed-upon set of comprehensive health maintenance and treatment services to a voluntarily enrolled group of individuals in a geographic area. Enrollees are charged a fixed, prenegotiated fee (capitation payment) that entitles them to the services offered by the HMO. The first sentence above describes the four principal characteristics of an HMO, each of which needs to be explained more fully.

An organized system of health care should provide the services of physicians or other health professionals, with the services of inpatient and outpatient facilities, and any other health services that a particular population might need. The system is organized in such a way as to give the enrollee an efficient and effective entry into the health care system. It also promises continuity of care for the enrolled population through linkages among the components of the system.

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*Michigan, however, currently requires that all individual health policies offer inpatient treatment for alcoholism and drug abuse as a benefit option and that all group policies offer both inpatient and outpatient treatment as benefit options.

Through comprehensive health maintenance and treatment services, the HMO provides (or arranges for the provision of) the health services that a population might require, including primary care, emergency care, and rehabilitation for chronic and disabling conditions.

An agreed-upon set of services means that the consumers and the HMO agree upon the services that will be purchased from the HMO in return for the membership fee. Since some HMOs may have groups of enrollees paid for by Medicare, or Medicaid, or by employer-employee arrangements, the benefit schedule for population groups may differ.

The enrolled group refers to those individuals or groups of people who voluntarily join the HMO through a contract arrangement in which the enrollee agrees to pay the HMO fixed monthly or other periodic payment (or have it paid on his behalf). The enrollee agrees to use the HMO as his principal source of health care if he becomes ill or needs care. The contract is for a specified period of time (most typically, one year).

The concept of the health maintenance organization grew from the success of a variety of medical foundations and prepaid group practice organizations in various parts of the United States that are now providing health care services for more than 7 million persons. Some of the better known examples of existing HMOs are the various Kaiser Foundation Health Plans, the Health Insurance Plan of Greater New York, the Group Health Cooperative of Puget Sound, in Seattle, Washington, and the Group Health Association of Washington, D.C.

An HMO can be organized and sponsored by either a medical foundation (usually organized by physicians), by community groups who bring together various interested leaders or organizations, by labor unions, by a governmental unit, by a profit or nonprofit group allied with an insurance company or some other financing institution, or by some other arrangement. The HMO may be hospital-based, medical-school-based, or be a freestanding outpatient facility or group of such facilities.

There are two basic types of HMOs--group practice associations and independent practice associations. Group practice associations provide services through physicians practicing together in an organized group, generally within the same facility. Independent practice associations are organizations of physicians who operate out of their own independent offices but who are coordinated through some type of organizational structure that provides administrative and financial management functions.

The federal government has recognized that HMOs represent a potentially valuable means of providing medical services to significant segments of the population. The Health Maintenance Organization Act of 1973 (P.L. 93-222) was signed into law on December 29, 1973. This act encourages the development of HMOs by authorizing temporary federal financial support in the form of grants, contracts, or loan guarantees for feasibility studies, planning, initial development, and expansion of HMOs. Additionally, P.L. 93-222 requires that employers who are governed by the federal minimum wage law and who employ 25 or more people include the option of membership in an HMO as part of any health benefits plan offered employees.

P.L. 93-222 requires that in order to qualify for assistance, an HMO must offer a comprehensive set of basic health care services, including treatment for drug and alcohol abuse. The federal regulations governing implementation of the law list services that an HMO must either provide or arrange to have provided.* Required services include:

> (5) Diagnosis, medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs:
>
> > (i) Diagnosis and medical treatment shall include detoxification for alcoholism or drug abuse on either an outpatient or inpatient basis, whichever is medically determined to be appropriate, in addition to treatment for other medical conditions;
> >
> > (ii) Referral services may be either for medical or for nonmedical ancillary services. Medical services shall be a part of basic health services; non-medical ancillary services (such as vocational rehabilitation, employment counseling), need not be a part of basic health services;

The above referenced requirements are significant for a drug treatment program; they require a new or expanding HMO seeking federal financial assistance to make the specified drug abuse treatment services available to its members, either directly or through an arrangement with an "outside" facility. Therefore, an HMO may choose to contract for such services with a drug treatment program and thus serve as a third party payer to the drug program. In such a case, provider and service eligibility requirements would be set by the particular HMO involved.

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* Section 110.102, Federal Register, 39 F.R. 37308, October 18, 1974

NATIONAL HEALTH INSURANCE

For the future, National Health Insurance (NHI) may provide a means of making health care services available to the general population through a federally assisted, prepaid benefits system. Many different proposals for NHI have been advanced but five bills are considered major proposals. Table 4.8 illustrates the five bills, their authors, and the extent to which drug abuse treatment is provided for by each, on both an inpatient and outpatient basis. An examination of Table 4.8 shows that only the Corman-Kennedy and Ulman bills specifically and clearly cover the treatment of drug addiction.

All of the NHI bills are still "in committee" and thus subject to change. Therefore, the information presented in Table 4.8 must be regarded as tentative and may or may not bear any relationship to any final NHI legislation.

Table 4.7

SUMMARY OF BENEFITS ALLOWABLE UNDER STATE LEGISLATION THAT MANDATES INSURANCE COVERAGE FOR TREATMENT OF DRUG ABUSE (AS OF OCTOBER 1975)

State	Bill No. and/or Title	Date Passed	Dollar Benefits	Days of Care	Location of Care	Deductible/ Co-Insurance
Nevada	Senate Bill #588	1975	Basic policy: $1,000	Not to exceed 10 days	Licensed hospital	None
				Not to exceed 30 days	Treatment facility or health facility certified by Bureau of Alcohol and Drug Abuse	
			Major Medical Policy: Maximum benefits: $800	Outpatient treatment for 180 days (If received inpatient, benefits must commence within 7 days.)	Either licensed hospital and/or treatment facility or health facility certified by Bureau of Alcohol and Drug Abuse	None
North Dakota	House Bill #1596	1975	None	70 days in any calendar year for inpatient; 140 days in any calendar year for partial hospitalization "combination" of inpatient and partial hospitalization; each day of inpatient equals 2 days of partial hospitalization.	Licensed treatment facility	None

Table 4.7 (Continued)

State	Bill No. and/or Title	Date Passed	Dollar Benefits	Days of Care	Location of Care	Deductible/ Co-Insurance
Minnesota	Accident & Health Insurance	1973	At least 20% of total patient days as allowed by policy	No less than 28 days each calendar year	Licensed hospital; residential primary treatment program as licensed by state and as recommended by M.D.	None
Wisconsin	Insurance Bill	1971		30 days in any calendar year for inpatient	Licensed hospital	None
			$500 in any 12 month period for outpatient		Hospital or out-patient treatment facility; or M.D. at any location	None

Source: Survey data from interviews with State Legislative Research Councils, by H-2, Inc.; Cary, N.C.

Table 4.8

SUMMARY OF INSURANCE COVERAGE FOR THE TREATMENT OF DRUG ABUSE AS CONTAINED IN FIVE NATIONAL HEALTH INSURANCE PROPOSALS

Number and Name of Legislation	Author	Coverage for Drug Abuse	
		Inpatient	Outpatient
H.R. 1, National Health Care Services Reorganization and Financing Act	Ulman	Excluded unless patient is in an "acute" condition	Yes (10 visits per year and subject to co-payment)
H.R. 21 (S.3), Health Security Act	Corman, Kennedy	Yes	Yes
H.R. 5990, National Health Care Act of 1975	Burleson	Not Clear	Not Clear
H.R. 6283, Comprehensive National Health Care Act of 1975	Young	*	*
H.R. 6222, Comprehensive Health Care Insurance Act of 1975	Fulton	**	**

* Drug abuse not specifically mentioned but presumably covered under mental health provisions: 45 days of inpatient care per year plus the equivalent of 50 outpatient visits per year.

** Drug abuse care would presumably be covered if acceptable to insurance carriers.

Source: Model Health Insurance Benefit Plan for the Treatment of Drug Abuse, H-2, Inc., Cary, N.C., for NIDA, December 17, 1975.

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SESSION 5

CONFIDENTIALITY

SESSION 5

LEARNING OBJECTIVES

Participants will review the basic issues in maintaining the confidentiality of clients' records.

At the end of this session and without the aid of notes the participants will be able to—

- identify at least two steps a program must take to ensure the privacy of client records;
- identify at least five confidentiality implications of third party payments for the client;
- identify at least two confidentiality implications of third party payments for program operations;
- prepare a legally valid consent form, given the type of data required by federal regulations.

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SESSION: 5

SESSION REQUIREMENTS	
PERSONNEL	Trainer
TIME	1 hour, 20 minutes
EQUIPMENT	Chalkboard
MATERIALS	Flip chart (F-13) Handout (H-4): Federal Register, 7/1/75
FACILITY	Large-group meeting room

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
10 min. LG M-L	Chalkboard	INTRODUCTION ● Define confidentiality as it relates to drug abuse programs. *Confidentiality concerns a program's legal and professional obligation to ensure the privacy of client information (i.e., a program cannot disclose information about a client without the client's knowledge and consent).* ● Explain the use of the term "client records." *Federal confidentiality regulations apply to client records--any written materials or oral communications that are related to identification, registration, diagnosis, prognosis, treatment, or other forms of assistance provided to past and current client.* ● Note that programs must prevent access to client information by unauthorized persons. *An authorized individual or organization is one who has a professional need or a legal right to know and who also has written consent for disclosure from the client.*
30 min. LG M-L		SIGNIFICANCE OF CONFIDENTIALITY ● Discuss both the professional and legal obligation of a program to ensure a client's right to privacy.
	Handout H-4 Federal Register 7/1/75	Mention that a client's file is a medical record Note the federal regulations (PL-92-255, §408, Handout H-4) Specify conditions for release of client data with and without consent Note the state regulations

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
		• Discuss the fact that a program must protect a client's right to privacy by-- a) preventing unauthorized access to client data b) restricting the nature and extent of information released *(Only information that is minimally necessary should be released)* c) obtaining informed consent for release of client data written voluntary (without coercion) specific as to purpose, extent of disclosure, date of signing and expiration, and receiver
	Flip Chart (F-13) Sample Client Consent Form	• Use the flip chart to discuss the client consent form (Refer to Sample Client Consent Form) • Note that when material is released to a third party it is the responsibility of the program to be certain that both public and private third parties understand confidentiality regulations.
20 min.	p. 200	CLIENT IMPLICATIONS • Discuss reasons a client might be reluctant to release information fear of job loss or diminished status fear of loss of welfare income fear of societal rejection fear of insurance repercussions fear by minors of parental disapproval • Discuss some ways for overcoming this reluctance, remembering always that it is the client's right to refuse consent for any reason.

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
20 min.	p. 200	PROGRAM IMPLICATIONS • Note the impact of the federal regulations on program administration. *a) Appropriate administrative procedures must be developed.* *b) Physical security of client records must be provided.* • Discuss the need for administrative procedures. a) Procedures for regulating access to client records should be written. b) These should establish methods for processing information, limiting access and providing accountability. c) A single staff member should process inquiries. d) Written records of requests and disclosures must be maintained. e) Inquiries and client consent forms must conform to federal and state regulations. f) Procedures should be developed to cover instances of release without consent. • Discuss the need for physicial security. a) Records must be kept in locked files. b) Access to files must be controlled by one staff member.
15 min. LG D		DISCUSSION • Answer any questions.

CLIENT CONSENT
FORM

I, ____,
(client/patient name)

authorize ____
(name of program to disclose information)

to disclose ____

____

____

____
(name or title of person(s) or organization(s) to which disclosure is to be made)

the following identifying information from my records

____
(specify extent or nature of information to be disclosed)

____

____

The purpose or need for such disclosure is ____________________

____

____

This consent to disclose may be revoked by me at any time except to the extent that action has been taken in reliance thereon

This consent expires on _______________________________________

____
(specify date, event, or condition upon which it will expire)

Signature of Client/Patient ______________________ Date __________

Signature of Witness ____________________________ Date __________

Signature of Parent or Guardian
or Legal Representative _________________________ Date __________

SECTION 5

CONFIDENTIALITY

CONFIDENTIALITY: A PROFESSIONAL AND LEGAL OBLIGATION

Drug abuse treatment programs have both a professional and legal obligation to preserve the confidentiality of client information.

Professional Obligation

As a professional organization collecting information of a personally-sensitive nature, programs must ensure that such information is treated in a confidential manner to protect their clients' right to privacy. The release of information regarding a history of drug abuse may be injurious to a client's rehabilitation, employability, and/or social well-being. It is the responsibility of the program to make certain that the client is not disadvantaged because of participation in treatment. Further, since a drug treatment program operates as a provider of medical services, client information becomes a medical record and must be treated accordingly.

Legal Obligation

The federal government recognizes the client's right to confidentiality. The right to confidentiality is specified in P.L. 92-255 (The Drug Abuse Office and Treatment Act of 1972), Section 408 as amended by P.L. 93-282 and in the Federal Regulations Part 2, Title 42, Confidentiality of Alcohol and Drug Abuse Patient Records. These regulations were published in the Federal Register of July 1, 1975 (pp. 27802-21). A detailed understanding of these regulations can be obtained through the self-instructional course in confidentiality prepared by the National Drug Abuse Center.

Applicability of the confidentiality regulations is extremely broad as they are relevant to any program receiving direct or indirect financial assistance from the federal government. Specifically, these regulations apply to any drug abuse function that:

- in whole or in part is conducted by grant, contract, or otherwise by any federal agency;

- in whole or in part must be licensed, registered, approved, or authorized for the lawful conduct of business by any federal agency;
- is assisted by funds supplied by any federal agency either directly by grant, contract, or otherwise, or indirectly by funds supplied by a federal agency to a state or local government through contracts, grants, general or specific revenue sharing;
- has been given tax exempt status by the Internal Revenue Service, or is allowable as an income tax deduction when contributions are made to it.

Where state regulations regarding confidentiality exist, they may supersede federal regulations only when the state regulation is more stringent. Otherwise no state law may either authorize or compel any disclosure prohibited by the federal regulations.

The federal regulations apply to all client records maintained by a program. "Records" are defined as "all oral communications and all written materials related to both past* and current clients." Records and information covered would include those relating to a client's identity, diagnosis, prognosis, treatment, program participation, or other information on the status of the client.

PROTECTING CLIENT'S RIGHT TO PRIVACY

Drug treatment programs are responsible for protecting the client's right to privacy by limiting disclosure, obtaining written consent from clients, establishing administrative procedures for ensuring confidentiality, and maintaining adequate security precautions. Penalties for violation are $500 for the first offense, and $5,000 for each subsequent offense.

Limiting Disclosure

The program must prevent access to client information by unauthorized persons. Only those individuals having a professional need to know, a legal right to know, and (where necessary) written consent of the client may obtain client information, and then only when the specified conditions are met. The nature and extent of the information released to authorized individuals or organizations is restricted to that which is minimally necessary to fulfill the purpose for the disclosure. Authorization does not mean carte blanche access to client information.

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*"Past clients" refers to individuals who received treatment after 3/21/72 and whose case files are subject to the regulations.

Obtaining Client Consent

The client must give his written, informed consent for release of information except under certain prescribed circumstances.* Informed consent means that the client fully understands the reasons for the disclosure and agrees to the release of the information. Additionally, the client's consent must be given freely, voluntarily, and without coercion. This is accomplished by having the client sign a written consent form specifying the following:

- Name of client
- Name of program making disclosure
- Name or title of person or organization to which disclosure is to be made
- Extent or nature of information to be disclosed
- Purpose or need (reason) for disclosure
- Statement that consent is subject to revocation, by the client, at any time (unless the provider has already taken action based on having obtained consent) and the specific time upon which the consent will expire without express revocation or renewal
- Signature of client and/or other signature as required**
- Date consent signed

---

*The specific circumstances under which client information can be released without prior consent are noted under the subtopic "IMPLICATIONS FOR THE PROGRAM" of this section.

**If the client is a minor and there is no state law permitting minors to obtain medical services without the approval of a parent or guardian, the consent form must also be signed by the client's parent or guardian.

An example of a consent form that you may want to use or modify is given in Figure 5-1.

IMPLICATIONS FOR THE CLIENT

The client may be apprehensive about consenting to the release of information. Clients may be reluctant to consent to releasing information about their participation in a drug abuse treatment program because of their concern regarding potential negative consequences that may occur as a result of the disclosure.

Clients who are employed when they enter treatment may fear that if their employers learn of their drug problem, they might be fired, moved to a less sensitive job, or that their potential for advancement might be diminished. Other apprehensions could be loss of a security clearance or general anxiety about being socially ostracized. Welfare recipients may fear loss of this source of income. A woman on welfare may fear that she will be declared an "unfit" mother and her children taken from her.

Clients or parents of clients who have insurance that covers drug abuse treatment may be reluctant to release information to the insurance company because they might then be considered a bad insurance risk.

Minors living in states where they may legally obtain medical treatment without parental consent, but whose parents may have private insurance or other third party coverage that will pay for their treatment, may be unwilling to attempt to obtain such reimbursement as it would require them to inform their parents of their treatment in order to obtain the needed insurance forms.

All of these fears are very real to some clients, and these situations can occur. It is the responsibility of the drug treatment program to assist the client in weighing the potential benefits and liabilities involved in consenting to release information. Remember, it is the client's right to refuse to give consent, for any reason, and he must not be coerced into giving it.

IMPLICATIONS FOR THE PROGRAM

Adherence to the federal confidentiality regulations affects a program in two basic ways--it creates a need to develop appropriate administrative procedures and establishes the necessity of providing for the physical security of client records.

Administrative Procedures

The program should develop written procedures for regulating and controlling access to client information. These procedures should establish methods for processing information obtained at various data collection points (registration, counseling, medical examinations, methadone dispensary, etc.), limiting access to client information, and providing for accountability.

One staff member should be designated to process inquiries and requests for client information. This person should be trained in the implementation of the confidentiality regulations and should be directed to maintain a record of all requests for information. Such a record should show who requested the information, the nature of the information requested, and the date of the request.

All inquiries for client information should be in writing. Exceptions to this are bona fide medical emergencies and circumstances in which an individual who is on medication, prescribed by a program, is in a situation where he is unable to provide written consent to his treatment program (e.g., traveling, hospitalized, incarcerated) and requires continuation or modification of his medication. In all of the above types of situations a written record after the fact is required to document the disclosure. All inquiries and client consent forms must be in conformity with federal and state regulations.

Administrative procedures should also be developed to cover the specific instances under which client information may be released without consent. These are:

- In case of medical emergencies
- For the purpose of scientific research, program audit or evaluation (as long as individual client identity is not disclosed by the recipients of this information and the information is not used for action against any individual)
- If authorized by a court order

  NOTE: A court order based on the authorizing legislation for the confidentiality regulations--21 U.S.C. 1175 and 42 U.S.C. 4582--only nullifies the prohibition against disclosure, it does not compel disclosure. A court order or provision of an order based on some other authority, or a subpoena, or other appropriate legal process, is required to compel disclosure.

- In the case of a minor who, in the opinion of the program director, lacks the capacity to make a rational decision on whether to consent to the notification of a parent or guardian, if such notification is necessary due to a "substantial life-threatening situation." In such a case, the relevant facts may be communicated to a parent or guardian.

Federal regulations permit the release of client information to third party payers only with the client's written consent. Such disclosure is limited to information that is reasonably necessary for the discharge of the contractual obligations of the third party payer. Where such third parties maintain records that identify the clients, they also must abide by the same regulations governing treatment programs. Therefore, they are also prohibited from unwarranted disclosure of client data. *It is the responsibility of the treatment program to make certain that both public and private third party payers understand that they are subject to the confidentiality regulations.*

The federal confidentiality regulations state that the following caveat (or one substantially the same) must accompany the release of client information to any individual or organization not directly subject to those regulations:

> This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42-CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Physical Security

Programs must take appropriate precautions for the security of records. Records containing any information pertaining to clients must be kept in a secure room, or locked file cabinet, safe, or similar container when not in use. Access to files should be controlled by one staff member. The records should reside in a secure file (preferably a central file), and there should be a sign-out procedure if possible. Records should be signed out in the morning and returned to the secure file prior to the close of business each day. If a record is kept out overnight, it should be stored in a locked file.

Client-related documentation that is subject to service audit* should be maintained in such a manner as to preclude identification of individual clients.

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*The item "service audit" as used here refers to governmental review to verify compliance with legal requirements.

CLIENT CONSENT
FORM

I, ______________________________,
(client/patient name)

authorize ______________________________
(name of program to disclose information)

to disclose to ______________________________

____

____

____
(name or title of person(s) or organization(s) to which disclosure is to be made)

the following identifying information from my records

____
(specify extent or nature of information to be disclosed)

____

____

The purpose or need for such disclosure is ______________________________

____

____

This consent to disclose may be revoked by me at any time except to the extent that action has been taken in reliance thereon.

This consent expires on ______________________________

____
(specify date, event, or condition upon which it will expire)

Signature of Client/Patient ______________________________ Date __________

Signature of Witness ______________________________ Date __________

Signature of Parent or Guardian
or Legal Representative ______________________________ Date __________

Figure 5.1. Sample Client Consent Form

*Prepared by the Connecticut Alcohol and Drug Council

SESSION 6

ADMINISTRATIVE CONSIDERATIONS

SESSION 6

LEARNING OBJECTIVES

Participants will examine major administrative implications that are likely to result from the implementation of a third party payments system.

At the end of this session and without the aid of notes the participants will be able to–

- identify at least three key questions that need to be answered before any steps are taken to implement a third party payment system;
- identify at least five management decisions that must be made before implementing a third party payment system;
- identify at least three staff issues to be addressed prior to implementing a third party payment system.

SESSION: 6

SESSION REQUIREMENTS	
PERSONNEL	Trainer
TIME	2 hours, 15 minutes to 2 hours, 55 minutes
EQUIPMENT	Chalkboard Flip Chart easels (1 per meeting room)
MATERIALS	Flip Charts (blank, 1 per small-group meeting room) Prepared flip charts (F-14, F-15)
FACILITY	Large-group meeting room Small-group meeting rooms (6 to 8 trainees per room)

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
		MANAGEMENT ISSUES
5 min. LG M-L		INTRODUCTION • Introduce the session by noting that implementation of a third party payments system requires certain administrative considerations: policies and procedures record keeping system development of a fee schedule billing and collection system • Prepare for a discussion on the feasibility of a third party payments system by noting the first question a program must consider: *Is it feasible for a given program to obtain third party payments?*
20 min. LG	Chalkboard	DISCUSSION • Initiate a discussion concerning considerations a program must make in determining third party payment feasibility. • List trainees' responses on the chalkboard. • Summarize key responses.
15 min. SG	Flip Chart	WORKSHOP (applies if more than 15 participants) • Divide trainees into groups of six to eight members and designate meeting rooms for each. • Provide a facilitator for each group (if possible), or have each group select a leader. • Note that the facilitator or leader will be responsible for conducting the discussion and recording points on the flip chart. • Ask each group to identify two or three of the most important administrative decisions they think must be made when implementing a third party payments system. • Note that a spokesman will report to the large group.

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
30 min. LG D		DISCUSSION • Ask spokesmen to report the results of their group's discussion. • Discuss these results within the large group. • Within the discussion, note that management decisions must consider: The development of a fee schedule and charging of clients A policy toward clients who cannot pay for services Programmatic changes that will be necessary to become eligible providers Billing and collection procedures *(remember that confidentiality must be ensured)*
		STAFF ISSUES *Option A (Workshop)*
5 min. LG M-L		INTRODUCTION • Note that programs must consider the impact on staff of introducing a third party payments system.
35 min. SG	Flip Chart Facilitator	WORKSHOP (applies if more than 15 participants) • Divide trainees into small groups as in the previous workshops. • Ask trainees to conduct their group discussion as they did earlier, this time focusing on two or three major staff issues that must be considered.
30 min. LG D		DISCUSSION • Ask spokesmen to report the results of their group's discussion. • Discuss and categorize the results.

Session 6: ADMINISTRATIVE CONSIDERATIONS: MANAGEMENT AND STAFF ISSUES

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
		• Discuss possible strategies for overcoming staff resistance to a third party payments system, considering the following: Analysis of the additional burden for staff Assignment of the additional skills staff will need and how they will develop these skills *Option B (Discussion)*
5 min.		INTRODUCTION • Note that programs must consider the impact on staff of introducing a third party payments system.
25 min. LG D		DISCUSSION • Initiate a discussion to identify some of the major staff issues to be considered. • Also discuss possible strategies for overcoming staff resistance to a third party payments system, considering the following: Analysis of the additional burden for staff Assignment of roles and responsibilities Determination of the additional skills staff will need and how they will develop these skills
		RECORD KEEPING
5 min. LG		SUMMARY • Summarize the discussions of management and staff issues from the previous day's session.
15 min. LG M-L		IMPORTANCE OF RECORD KEEPING • Note that records that maintain client information are necessary for effective program management.

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
		• Note that the TPP records should document: Client eligibility status Payer information *(e.g., identification of payer, services covered, limits on services provided, and related costs)* Billing and collection status *(e.g., costs incurred as a result of services provided, reimbursement sources for costs incurred, and reimbursement status)*
		• Note that HSF Regulations require that programs maintain and regularly update (at least annually) client eligibility records.
		• Also note that the regulations require that programs inform clients of their rights and responsibilities in the area of third party coverage and assist clients in applying for that coverage.
		• Discuss the types of records that should be maintained.
	Flip Chart F-14 (Figure 6.1) p. 228	a) Client Third Party Eligibility Data (to be collected at intake) Client's knowledge of the eligibility for reimbursement Age, sex, of client and family Family income and source(s) Additional monetary resources available to client's family Identification of any physical or mental impairment or disability
	Flip Chart F-15 (Figure 6.2) p. 229	b) Encounter Records Services provided Date of service Provider of service
		c) Billing and collection records

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
10 min LG		DISCUSSION ● Answer any questions.
5 min LG M-L		SUMMARY ● Summarize key points of the session.

CLIENT THIRD PARTY ELIGIBILITY DATA

NAME: LAST, FIRST, MIDDLE INITIAL

DATE:

PHONE:

ADDRESS: STREET, CITY, STATE, ZIP CODE

1.	AGE	SEX
CLIENT		
OTHER FAMILY MEMBERS		

2. TO YOUR KNOWLEDGE, ARE YOU ELIGIBLE FOR ANY OF THESE PROGRAMS?

	YES	NO	UNCERTAIN
MEDICAID	☐	☐	☐
TITLE XX	☐	☐	☐
PERSONAL INSURANCE	☐	☐	☐
COMPANY: ______			
GROUP INSURANCE	☐	☐	☐
COMPANY: ______			
OTHER:	☐	☐	☐

______

______

3. FAMILY INCOME

ANNUAL:
$

MOST RECENT QUARTER:
$

4. SOURCE OF INCOME:

☐ SSI ☐ AFDC ☐ OTHER

☐ EMPLOYMENT: NAME ______

ADDRESS ______

______

☐ OTHER (LIST): ______

______

5. FAMILY RESOURCES:

☐ OWN HOME: $ ______ EQUITY

☐ OWN CAR: $ ______ EQUITY

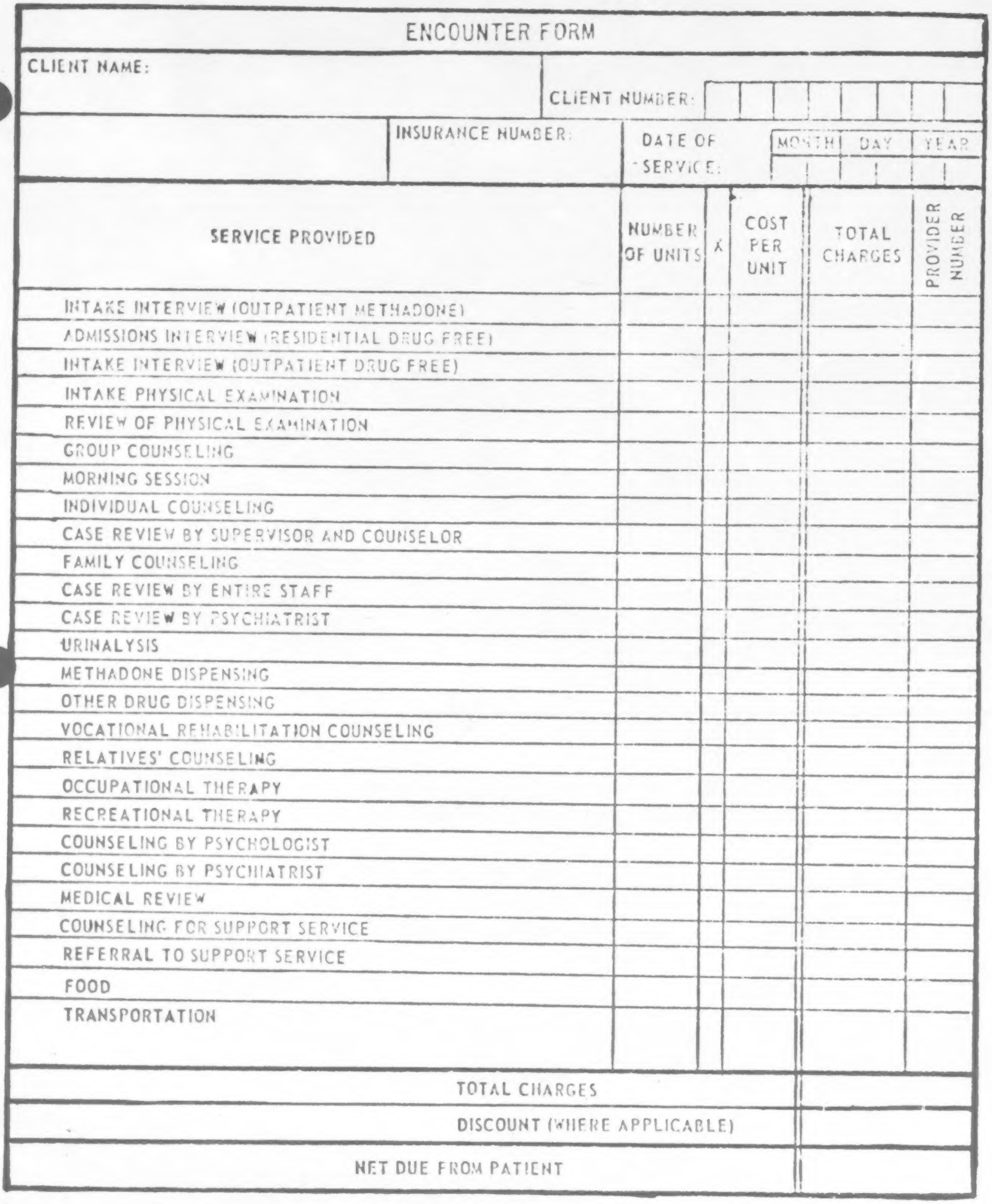
☐ CASH: $ ______ AMOUNT

☐ OTHER (DESCRIBE): ______

______

6. ARE YOU CURRENTLY DISABLED? (DESCRIBE):

Sample Flip Chart F-14



ENCOUNTER FORM

CLIENT NAME:

CLIENT NUMBER:

INSURANCE NUMBER:

DATE OF SERVICE: MONTH | DAY | YEAR

SERVICE PROVIDED	NUMBER OF UNITS	X	COST PER UNIT	TOTAL CHARGES	PROVIDER NUMBER
INTAKE INTERVIEW (OUTPATIENT METHADONE)					
ADMISSIONS INTERVIEW (RESIDENTIAL DRUG FREE)					
INTAKE INTERVIEW (OUTPATIENT DRUG FREE)					
INTAKE PHYSICAL EXAMINATION					
REVIEW OF PHYSICAL EXAMINATION					
GROUP COUNSELING					
MORNING SESSION					
INDIVIDUAL COUNSELING					
CASE REVIEW BY SUPERVISOR AND COUNSELOR					
FAMILY COUNSELING					
CASE REVIEW BY ENTIRE STAFF					
CASE REVIEW BY PSYCHIATRIST					
URINALYSIS					
METHADONE DISPENSING					
OTHER DRUG DISPENSING					
VOCATIONAL REHABILITATION COUNSELING					
RELATIVES' COUNSELING					
OCCUPATIONAL THERAPY					
RECREATIONAL THERAPY					
COUNSELING BY PSYCHOLOGIST					
COUNSELING BY PSYCHIATRIST					
MEDICAL REVIEW					
COUNSELING FOR SUPPORT SERVICE					
REFERRAL TO SUPPORT SERVICE					
FOOD					
TRANSPORTATION					

TOTAL CHARGES	
DISCOUNT (WHERE APPLICABLE)	
NET DUE FROM PATIENT	

Sample Flip Chart F-15

SECTION 6

ADMINISTRATIVE CONSIDERATIONS

Third party payments and financial management procedures are closely interrelated. Improved financial management will generally increase a program's potential for collecting third party payments. Income from third party payments can help to broaden the base of financial support for the program. The interrelationship between financial management and third party payments is clear in the Guidelines and Regulations for Health Services Funding discussed in Section 2.

Thus, third party payments impact broadly on the administrative and financial management procedures of a program. This section discusses these implications in two areas of program management: policies and procedures and recordkeeping. Other considerations, development of a fee schedule and billing and collection procedures will be discussed in Section 7.

POLICIES AND PROCEDURES

Certain basic questions must be answered before a program can effectively implement a third party payments system. These are:

1. What are we trying to accomplish?

   Will the program undertake a major effort to establish a third party billing and collection procedure? What percentage of its total revenue will the program expect from third parties? What are the sponsoring agency's expectations? What is the current experience with the client population? Is the program undertaking this action merely to meet federal, state, or local requirements or on the basis of well-planned financial management decisions?

2. What resources should be utilized?

   Will external resources be used in billing and collection activities? Are any resources available from a major institution that backs up the program? Will a major investment be made in people and equipment in order to effect a billing and collection program? Who in the program's organization will be primarily responsible for this function?

3. How well must it get done?

What level of success is expected by the program director and the governing body? How will accomplishment be measured?

Answers to the above questions will provide the basis for a sound management structure for implementing a third party payments system.

Once the decision is made to seek third party funds, basic management decisions are required in the areas of planning, organizing, and managing the collection of revenues from clients or third parties. Specific policies must be developed relative to the implementation and use of a third party payments system and procedures for executing them must be developed. These policies will relate to such factors as:

- Nature and extent of charges to be made for services rendered
- Procedure for obtaining third party information from clients
- Procedure for obtaining client consent to release information to third party
- Protection of client information
- Use of third party revenues
- Provider eligibility requirements
- Maintenance of financial records
- Development of a billing and collection system

RECORD KEEPING

The third party reimbursement mechanism requires paperwork. Third parties simply will not pay for services unless they have evidence that the service was performed, that it is covered by the policy, that the recipient is eligible, and that the provider was qualified. The insuror also wants to be sure that the charges are reasonable.

Part of the input to this system will be from records that identify eligibility completed at the time of the client's entry into the program. An accurate record of eligible encounters must back up each billing. This information could be maintained on the same record, one that identifies eligible services and payers and also provides space to record visits and billings to the payers. A separate set of records should be maintained to record receipt of payments from third party payers and clients.

Requirements regarding the identification of clients who are eligible for third party assistance are outlined in the Health Services Funding Regulations, as follows:

50.105

(e) An ongoing procedure to identify all persons served who are eligible for third-party reimbursement.

Discussion

Projects must establish and maintain standard registration and record-keeping procedures to identify and update information on the third party coverage and eligibility status of individual project users. These procedures should be contained in procedural manuals which are updated as needed. The procedures should include those needed to:

(1) Obtain accurate information on such items as age, residence, income, family size, present third party coverage, etc., without offending the dignity of the patient.

(2) Verify the information as frequently as needed (at least annually) to maintain accurate information.

(3) Inform patients of their rights and responsibilities in the area of third party coverage and assist them to formally apply for any applicable coverage(s).

The HSF Regulations also identify additional information that should be recorded as part of a sound management system: financial data, registration data, staff productivity, and services utilization data.

Financial data and reports. Projects should maintain sufficient financial records and statistical data for proper determination of costs. Standardized definitions, accounting, statistics, and reporting practices which are widely accepted in the health care and social therapeutic fields should be used or followed. Cost information should be current, accurate and in sufficient detail to support operation of the project, satisfy national reporting requirements and determine rates applicable to third party payors. This includes all ledgers, books, records and original evidences of costs (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, valuation of in-kind contributions, labor time cards, payrolls, bases for allocating costs, etc.). Projects should develop and maintain internal controls to insure the integrity and adequacy of its systems and procedures. An annual fiscal audit by an independent auditing firm should be considered an effective management tool as well as substantiating the project's own cost figures when negotiating with third party payors.

Registration and other patient data information systems. Appropriate medical record, registration and encounter (or clinic visit record) systems should be instituted in order to allow the project to collect, record and maintain current information on patients, including patient identification, third party payor coverage, ability to pay for services, and actual service utilization.

Information on direct service personnel productivity and services utilization in order to allow for an assessment of overall project efficiency.

Types of Records

A program must maintain written records that document clients' eligibility status, payer information, services provided and their costs, and billing and collection status.

Client Third Party Eligibility Status

Certain basic data relevant to the client's eligibility for third party reimbursement should be obtained at the point of intake. The type of information to be obtained from the client should include:

- Client's knowledge of his eligibility for third party reimbursement
- Identification of any physical or mental impairment or disability
- Age, sex, and relationship of other members of client's family
- Family income and source(s)
- Additional monetary resources available to client's family

A sample form for recording this information is shown in Figure 6.1.

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Encounter Records

Encounter records identify what services were provided on what dates and by whom. For general program purposes it is a good idea to keep this information, but it is essential that it be kept for preparing bills and in providing documentation of charges to clients and third party payers. An example of an encounter form is shown in Figure 6.2.

Billing and Collection Records

These records document a program's third party reimbursement efforts. Programs should establish an accounts receivable system to show which bills have been paid and which have not.

A final set of records show the program's third party reimbursement payments and their percentage of total income. These records should include the different sources of payment. This information will help in analyzing cost structures and in evaluating and updating rate schedules. The information is also necessary to evaluate and monitor the efficiency of the third party reimbursement system.

SUMMARY OF ADMINISTRATIVE CONSIDERATIONS

Use of the third party payment system will, indeed, place additional demands upon your program. Intake procedures may have to be revised. Extra care in documentation and validation, as well as strict adherence to the use of release forms will be required.

However, there are many positive outcomes to developing third party payments. Third party payers supply needed revenue. The incorporation of third party payments into your program can provide the opportunity for self-assessment, and offers a chance to institute policies and procedures that can enhance the efficiency and credibility of your program.

CLIENT THIRD PARTY ELIGIBILITY DATA

NAME: LAST, FIRST, MIDDLE INITIAL

DATE:

PHONE:

ADDRESS: STREET, CITY, STATE, ZIP CODE

1.	AGE	SEX
CLIENT		
OTHER FAMILY MEMBERS		

3. FAMILY INCOME

ANNUAL:
$

MOST RECENT QUARTER:
$

2. TO YOUR KNOWLEDGE, ARE YOU ELIGIBLE FOR ANY OF THESE PROGRAMS?

	YES	NO	UNCERTAIN
MEDICAID	☐	☐	☐
TITLE XX	☐	☐	☐
PERSONAL INSURANCE	☐	☐	☐
COMPANY:			
GROUP INSURANCE	☐	☐	☐
COMPANY:			
OTHER:	☐	☐	☐

4. SOURCE OF INCOME:

☐ SSI ☐ AFDC ☐ OTHER

☐ EMPLOYMENT: NAME ______

ADDRESS ______

☐ OTHER (LIST): ______

5. FAMILY RESOURCES:

☐ OWN HOME: $ ______ EQUITY

☐ OWN CAR: $ ______ EQUITY

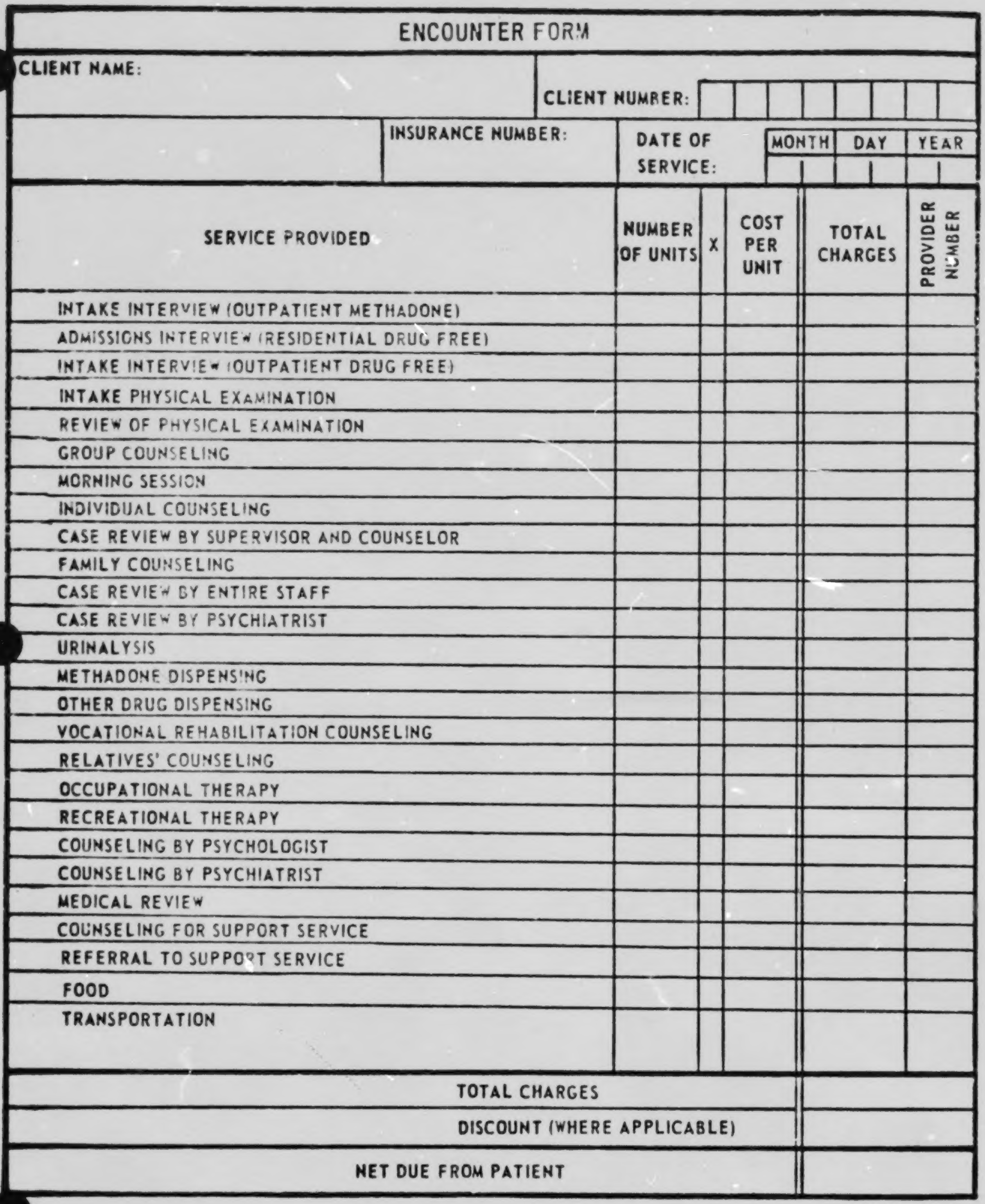
☐ CASH: $ ______ AMOUNT

☐ OTHER (DESCRIBE): ______

6. ARE YOU CURRENTLY DISABLED? (DESCRIBE):

Figure 6.1

*Source: NIDA Financial Management Seminar by Macro Systems, Inc.



ENCOUNTER FORM

CLIENT NAME:

CLIENT NUMBER:

INSURANCE NUMBER:

DATE OF SERVICE: MONTH | DAY | YEAR

SERVICE PROVIDED	NUMBER OF UNITS	X	COST PER UNIT	TOTAL CHARGES	PROVIDER NUMBER
INTAKE INTERVIEW (OUTPATIENT METHADONE)					
ADMISSIONS INTERVIEW (RESIDENTIAL DRUG FREE)					
INTAKE INTERVIEW (OUTPATIENT DRUG FREE)					
INTAKE PHYSICAL EXAMINATION					
REVIEW OF PHYSICAL EXAMINATION					
GROUP COUNSELING					
MORNING SESSION					
INDIVIDUAL COUNSELING					
CASE REVIEW BY SUPERVISOR AND COUNSELOR					
FAMILY COUNSELING					
CASE REVIEW BY ENTIRE STAFF					
CASE REVIEW BY PSYCHIATRIST					
URINALYSIS					
METHADONE DISPENSING					
OTHER DRUG DISPENSING					
VOCATIONAL REHABILITATION COUNSELING					
RELATIVES' COUNSELING					
OCCUPATIONAL THERAPY					
RECREATIONAL THERAPY					
COUNSELING BY PSYCHOLOGIST					
COUNSELING BY PSYCHIATRIST					
MEDICAL REVIEW					
COUNSELING FOR SUPPORT SERVICE					
REFERRAL TO SUPPORT SERVICE					
FOOD					
TRANSPORTATION					
TOTAL CHARGES					
DISCOUNT (WHERE APPLICABLE)					
NET DUE FROM PATIENT					

Figure 6.2

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SESSION 7

FINANCIAL MANAGEMENT

SESSION 7A

LEARNING OBJECTIVES

Participants will examine the major financial considerations involved in the implementation of a third party payments system.

At the end of this session and without the aid of notes, the participants will be able to–

- identify the two types of fee schedules;
- identify at least two categories of program costs;
- specify the proportion of indirect costs related to direct costs, given a hypothetical cost structure for a program.

SESSION: 7 A

SESSION REQUIREMENTS

PERSONNEL	Individual familiar with development of fee schedules
TIME	1 hour, 45 minutes to 2 hours
EQUIPMENT	Chalkboard or flip chart
MATERIALS	None
FACILITY	Large-group meeting room

Session 7: FINANCIAL MANAGEMENT

Option A: Lecture Presentation

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
		Note to Trainer: *This session may be conducted in one of two ways. Option A involves the use of an individual with experience in the development of fee schedules for health care providers. The method of presentation and specific subject matter may be left to the instructor's discretion, or he may use the following topic outline.*
10 min. LG M-L	Chalkboard or flip chart	INTRODUCTION ● Define "fee schedule". ● Discuss the significance of a fee schedule. ● Note the prerequisites to developing a fee schedule.
45-60 min. LG M-L		COST DETERMINATION ● Define the basic terms. ● Discuss various methods of determining costs of services. ● Discuss personnel requirements. ● Discuss the possible need for outside assistance.
30 min. LG M-L		FEE SCHEDULES ● Identify the two types of fee schedules: uniform charge structure and sliding fee schedule. ● Discuss the advantages and disadvantages of each type of fee schedule. ● Discuss the development of the uniform charge fee schedule and of the sliding fee schedule.
20 min.		DISCUSSION ● Answer any questions.

SESSION 7B

LEARNING OBJECTIVES

Participants will examine the major financial considerations involved in the implementation of a third party payments system.

At the end of this session and without the aid of notes, the participants will be able to—

- identify the two types of fee schedules;
- identify at least two methods of identifying costs of services to programs;
- specify the proportion of indirect costs related to direct costs, given a hypothetical cost structure for a program.

SESSION: 7B

SESSION REQUIREMENTS	
PERSONNEL	Trainer
TIME	1 hour, 40 minutes
EQUIPMENT	Flip charts and chalkboards (one for each meeting room)
MATERIALS	
FACILITY	1 large group meeting room Small-group meeting rooms (3 or 4)

Session 7: FINANCIAL MANAGEMENT

Option B: Discussion

IME/ ORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
		Note to Trainer: *Option B of this session is intended to maximize group participation and minimize trainer involvement. It should be used if there is no accounting expert available. If you are not well versed in the field, there will probably be some in the group who have experience that can be shared during the session.*
10 min. LG M-L		INTRODUCTION • Explain that the procedure for this session will involve individual study and small-group discussion.
	p. 247	• Define "fee schedule." *A fee schedule is a list of services provided by the project or agency and the price charged for each.*
		• Note that a fee schedule is necessary to ensure that the provider receives compensation for the costs incurred in providing service and to provide the basis for standardization of client charges.
	p. 255	• Note the two basic types of fee schedule: *A uniform charge structure establishes a uniform charge for all clients for the same services.* *A sliding fee schedule establishes the charge for a service based on the client's ability to pay (i.e., availability of third party coverage or personal financial resources).*
		• Note that some third party payers require that a provider of service apply a uniform charge structure for all services rendered.
15 min. I		INDIVIDUAL STUDY SESSION • Explain to participants that they are to read the section on Financial Management in their handbook. Explain that after they have finished reading they will be divided into small groups to discuss cost determination.

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
30 min. SG	Flip charts/ Chalkboards	WORKSHOP (if more than 15 participants)
		● Divide participants into groups of approximately six members, with SSA members assigned to each group.
		● Ask each group to select a leader to direct the discussion and record significant points on the flip chart.
		● Ask each group to discuss the question: *How do I identify the cost of services in my program?*
		● Mention that the group leader should develop two lists: (1) methods of identifying costs of services that apply to all programs represented in the groups (2) methods of identifying costs of services that apply to individual programs only
15 min. LG D		DISCUSSION
		● Have group leaders report on their group's findings.
	Chalkboard	● Combine and summarize results (list on chalkboard).
15 min. I		INDIVIDUAL STUDY SESSION
		● Ask participants to individually answer the question: *What do I need to do in order to begin the process of developing a fee schedule?* (e.g., what information do I need? What skills do I need? What steps should I take?)
		● Ask participants to write out their preliminary answers to these questions and keep for use when they return to their programs.

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
15 min. LG D		DISCUSSION • Encourage participants to identify the key questions that will have to be answered in order to determine the costs of services. • Answer any questions.

SECTION 7

FINANCIAL MANAGEMENT

DEVELOPMENT OF A FEE SCHEDULE

All providers of drug treatment services who wish to be reimbursed by a third party payer must have a fee schedule. This is a list of services provided by the project or agency and the price charged the client for each.

A typical fee schedule would include specific charges for each type of service provided (e.g., individual counseling, group therapy session, methadone administration), each type of medication used (e.g., methadone), and fees for special services such as lab tests.

A fee schedule is necessary to ensure that the provider receives compensation for the costs incurred in providing service and to provide the basis for standardization of client charges. Having a schedule also makes the provider more acceptable to third party payers. Most insurance companies and publicly financed health programs require a fee schedule before they will authorize benefits.

The technical aspects of developing a fee schedule are beyond the scope of this manual. A basic overview of the steps to be taken in developing a fee schedule will be given; the cost elements that should be considered will be highlighted.

The basic prerequisite for the development of a fee schedule is determination of costs; you can't know what to charge for a service until you know what it costs you to provide it.

Accounting System

In order to determine costs of services, it is necessary to have a reliable and accurate accounting system. Such a system should operate on the accrual basis. In the accrual basis of accounting income is recorded at the time it is earned, rather than when it is received. Likewise, expenses are recorded at the time they are incurred, rather than when they are paid. Hence, the accrual basis allows for periodic evaluation of an organization's financial status. An organization reporting on the accrual basis would consider costs billed to Blue Cross-Blue Shield as income at the time of billing. It would record as expenses all bills when they arrive, irrespective of when those bills are paid. The "accounts receivable" and the "accounts payable" are developed from this basis. This system involves double entry bookkeeping and a competent person to operate it.

Of importance to agencies that must recognize the inability of some clients to pay for services is a write-off mechanism that is noted in the receivable accounts of accrual basis accounting. The write-off mechanism accounts for uncollectible billings.

The other basis for accounting is called the cash basis, and operates just about the same as your personal checkbook. If you have ever had to count on next week's paycheck, knowing that certain bills were waiting to be paid, you can see the merit of the accrual basis of accounting.

Expenses

Expense accounts, that is, costs of the project, can generally be divided into two categories: direct costs and indirect costs.

Indirect Costs

Conventionally, indirect costs cover administrative and supportive expenses. They include outside activities such as legal and consultant services to the project, rental of space and equipment, and salaries and benefits of administrative employees.

Direct Costs

In providing treatment for drug addiction, each separate encounter is likely to involve several different services. The expenses incurred in providing each of these services are called direct costs. An accounting system should allow for easy accumulation of direct costs. Each direct cost needs to be identified. Examples of direct costs are: staff time, pharmaceuticals and other supplies used, laboratory fees.

One means of identifying client staff costs is to have each staff member keep records identifying the type of service performed and the time devoted to it. These times would then be accumulated by service and costed by the salaries involved. You would then know how much it costs to provide each service, exclusive of administrative costs.

Administrative costs should be allocated to each service. One procedure for making this allocation is to assign administrative costs in direct proportion to the cost of the service as related to the costs of all services. For example, if counseling costs are 25 percent of all direct service costs in your program, the associated administrative costs would be 25 percent of all administrative costs.

It may or may not be program policy that all program costs be allocated to the fee schedule. A fund accounting system will be able to separate out those expense items that should not be charged to the client or that have a funded source of support.

Relatively simple accounting systems can be set up for a reasonable one-time charge by a local accounting firm; however, as a project grows large and more financial information is needed by both management and outside interested parties, the presence of a permanent fiscal officer is desirable.

Fund Accounting

Most nonprofit health service organizations employ fund accounting to separate monies over which outside forces have control from those that are entirely at the discretion of the Board of Directors. Grants that come from federal and state agencies are considered to be restricted funds, because the provider of the money has detailed the ways in which it may be spent. All monies not restricted are "general fund" monies. As a result of pressures from the National Health Council, fund accounting has become widely used in recent years.

Further information on handling of fund accounting may be obtained from the National Health Council Standards for Accounting prepared by the American Institute of Certified Public Accountants. The standards are available from the National Health Council, 1740 Broadway, New York, New York 10019. The United Fund agency in your area should be able to provide assistance in understanding and using fund accounting principles. Another useful resource is the book Accounting for Non-accountants.*

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*Myer, John N. Accounting for Non-accountants. New York: Hawthorn, 1968.

Determining Costs of Services

Once the expense accounting has been accomplished, it is necessary to further allocate expenses to the major functional components of the program. This further division is necessary to define cost categories that will serve as a workable basis for the build-up of a cost for a particular unit of service. Program costs can generally be divided into the categories: direct costs, ancillary costs, and indirect costs.*

- Direct Costs are those costs that are directly attributable to the provision of client-related services. Examples of such costs are staff costs, laboratory costs, consumable supplies, etc.
- Ancillary Costs are those costs incurred to support the drug treatment delivery system with services such as outreach, program evaluation, food services.
- Indirect Costs are those costs not directly related to the provision of services, but which support the management of the program.

In order to determine the cost of each service provided, it is necessary to determine the various direct, ancillary, and indirect cost elements in it, and then estimate the extent to which each cost element is involved (e.g., hours of staff time, cc's of methadone).

Direct Costs

The major element in direct costs is staff costs. Staff costs per unit of service (e.g., counseling session) can be calculated by determining the average amount of staff time per staff category (e.g., counselor, senior counselor, lab technician, etc.), per encounter and multiplying this figure by the average salary per staff category.

Example: The time spent in five counseling sessions conducted by three different counselors was recorded for program X. The times and counselor salaries (hourly) were as follows:

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*This material is based on information presented in the NIDA Financial Management Seminars.

TIME PER SESSION (minutes)	COUNSELOR SALARIES (hourly)
40	$6.15
30	6.50
35	6.60
45	6.50
35	6.60

In the above example, the average time per counseling session is 37 minutes and the average hourly salary for a counselor is $6.47. Thus, in this case, the estimated staff cost per counseling session is $3.95.

A similar procedure is used to estimate the amount of "other direct costs" (i.e., direct costs other than staff). For the purpose of our example, let us assume that a permanent taped record is made of each counseling session at a cost of $1.25 per tape. This, then, would be an "other direct cost." Adding this cost to the cost of the staff time would bring the total direct cost of each counseling session to $5.20.

Ancillary and Indirect Costs

Ancillary and indirect costs represent those costs that are not directly attributable to the provision of client-related services. Since such costs are incurred as the result of their role in the support of the entire program, they must ultimately be distributed to each of the services provided.

This distribution process allows each service to share in the absorption of the ancillary and indirect costs. However, some services must be provided to more clients than others, some require more space than others, and some cost more to deliver than other services. Consequently, those services that constitute a larger portion of the total services provided by a program should receive a larger distribution of the total ancillary and indirect costs.

The total of the ancillary and indirect costs must be determined and then allocated to the various services. The manner in which the ancillary and indirect costs are allocated to each type of service is based upon a logical relationship between all services and a variable, such as office space or other direct cost. A number of different variables may be used for this purpose.

The individual cost components of the total ancillary and indirect cost can also be allocated separately based upon different variables. For example, the indirect cost of office space could be allocated to each service based upon the square footage that each service uses, whereas the indirect cost of administrative materials could be allocated based upon the number of clients a particular service serves. Other ancillary and indirect costs might be allocated based upon other logical variables.

Ancillary and indirect costs can be allocated to each type of service according to the proportion of the total direct costs allocated to that service. If, for example, the direct counseling costs are 25 percent of all direct service costs, the associated ancillary and indirect costs could be estimated to be 25 percent of all such costs. Thus, if the annual total of all ancillary and indirect costs for the program are $35,000, then $8,750 would be allocated to counseling services. Assuming that the program provides a total of 3,000 counseling sessions per year, the ancillary and indirect costs per counseling session would be $2.92.

Thus, in our example, the total cost of a counseling session would be $8.12 (3.95 + 1.25 + 2.92).

Once determined, costs of services are sorted by categories of expenses: employee benefits, contracted services, administrative expenses, space rental, and consumables (supplies and depreciation of durable equipment). These categories are usually set on a functional basis. For example, the entire cost of having an employee (payment of fringe benefits, overhead, etc.) is considered a salary expense. Another example involves contracted services, which pertain to the operation of the program, and not to expenses incurred from referring clients to such services. These contracted services would fall into a category that might be called client services. New categories are established when expense areas do not "fit neatly" into existing categories. The object of expense categories is to limit the number of expense accounts and still have a functional description of expenses. Your accounting system should allow for specific identification of cost areas within any category, whenever that information is necessary.

Based upon agreements with various third party insurers, there may be some limited types and levels of services that will be billed on a limited cost basis. For example, a funding agency may be willing to pay treatment costs of a program exclusive of the general administrative costs.

Shorthand Costing Method

A simple approach to estimating the costs of service is to first list every service you perform for your clients. Then identify which staff members are involved in providing this service. Determine the amount of time (on the average) each staff member spends with a client. Next, identify what, if any, medication, materials and/or supplies are used and the amount of each. Finally, relate the staff time and materials used to the cost of each encounter, based on some type of unit measure (e.g., hour of time, cc of methadone, etc.). You would also be wise to include a percentage of your overhead and the depreciation of durable equipment in your calculations.

For example, in a methadone maintenance clinic, you could watch several clients as they come in for service. Observe the procedure carefully. The clients come in, go to a clerk and state their names. The clerk pulls the clients' records and has them fill out forms or answer questions. In all, the clerk spends an average of ten minutes with each client before sending him to a nurse. The nurse does a quick check of temperature and blood pressure, asks a few more questions, then hands the client a paper cup containing the methadone. She spends an average of five minutes with each individual. Additionally, clients may also see a counselor for 20 minutes.

Now look at the visit in this way:

Personnel	Hourly Salary	Per Client Cost
One nurse for 5 min.	$10.00	$ .80
One clerk for 10 min.	3.00	.50
One drug counselor for 20 min.	6.00	2.00
Supplies		
One paper cup		$ .05
Pharmacy		
Methadone		$1.00
	TOTAL	$4.35

Service Unit Costing

Another approach to cost determination is service unit costing. Service unit costing describes the process of incorporating the estimate of what it costs a program to deliver specific health care services with the estimate of the units (or encounters, visits, sessions, consultations, etc.) of service to be used by the program's clients. In other words, it's like dividing a pie (the total cost of operating a program) into the number of pieces that will feed a certain number of guests (the service units).

Basic to the calculation of service unit costs is the determination and accounting for the program expenses incurred in the delivery of services. Simply put, all the dollars spent to provide the various services to the clients such as physical examinations, ancillary testing, medication, etc., must be accumulated and allocated over the anticipated number of times each service will be given.

These two methods, shorthand costing method and service unit costing, are not thoroughly detailed nor are they exhaustive. Your accounting firm may devise a method that will be more appropriate for your operation. However, some type of computation must be used to arrive at a reasonable fee for every service you provide.

You also need to consider the cost to your program of those clients who don't pay or those for whom reimbursement is only partial. For example, your cost for each administration of methadone may be $4.35, but Medicaid may only allow $4.00 for this type of service. The $.35 difference per client visit must be charged to grant-in-aid or some other income source.

Establishing a Fee Schedule

Once costs for each service have been determined, charges for these services can be set. Generally the charge to be made for a service will be the actual cost of providing the service plus an allowance for uncollectible costs. However, your program may be able to absorb unrecoverable costs through the use of grant monies. In this case, your fee will be a direct reflection of your cost.

Charges are generally made on either a "fee-for-service" or "unit-of-service" basis. In a fee-for-service approach, a charge is made for each functional activity performed (e.g., in a methadone maintenance program, individual charges would be made for counseling urinalysis, and dispensing). In the service-unit method, a single charge is made that covers the various functional activities involved in performing a given type of service, generally based on a given time frame. Hospitals, for example, use the service-unit approach in their daily room rate, which covers such items as nursing services, residents, orderlies, housekeeping, meals, etc. If the methadone program used the service unit method, a single charge could be made that would cover all of the functional activities involved.

There are two basic methods you can use (or adapt) to charge for your services. These are a uniform charge structure and a sliding fee schedule. Under the uniform charge structure, all clients are charged the same fee. Under a sliding fee schedule, the charge for a service is based on the client's ability to pay (based on availability of third party coverage and/or personal financial resources). With the sliding fee schedule, the charge made will in many cases be less than the cost of providing the service. Sliding fee charges are generally graded from the actual cost of the service to zero. Where a uniform fee structure is used, all clients are charged the full cost of the service; however, this charge may have to be waived (written off) for those clients unable to afford that amount.

Application of the sliding fee scale has presented problems with some third party payers. Many Medicaid programs and some private insurers require that a provider of service apply a uniform charge structure for all services rendered. It is important that a program check out such regulations and abide accordingly. The use of the sliding scale for payment based on ability to pay has been largely confined to federally or state-funded programs.

It is imperative that a bill be written up for each client receiving services from a program. This is necessary for a sound accounting system as well as for cost finding that relates to cost determination.

Many third party payers require that a uniform charge be made for all services to all clients. This does not mean that the program is expected to collect all or even any of the costs from the client, but the accounting system must show that such a charge was made against some income source. For example, if you bill Medicaid $5.00 for the administration of methadone, your accounting system must show that a $5.00 charge was made against your grant-in-aid (or some other) account for the administration of methadone to a client who is unable to pay for the service and is not eligible for any third party reimbursement. In some cases, the charge for a service might be accounted for by allocating the cost to two or more income sources.

Example:

Total cost of service		$35
Title XX	$15	
Client fee	15	
Grant-in-aid	5	

It is a sound practice to issue bills, even if the philosophy of your center has been to provide help whether the client is able to pay or not, because most insurance plans and publicly financed third party payers will not pay for care that is available free of charge. Some clients may well be able to pay for your service. For indigent clients, bills may be issued and then waived.

There are five basic methods of reimbursement:

- Direct cash payment
- Benefit waiver
- Direct reimbursement to client
- Reimbursement after discount/deductible
- Periodic interim payment

In direct cash payment, the client personally pays for services received.

In the benefit waiver (or assignment) form of payment, the client signs a legal release to waive his legal rights to benefits and to direct the insurance company to pay all money directly to the provider. The insured is bypassed completely once the assignment is received; the provider sends bills to the third parties and receives payments directly from them.

In direct reimbursement to client, the insured gets the money from his insurance company and then pays the provider. The provider normally still sends the claim to the insurance company and bills the client for charges that are not covered by the third party.

Reimbursement after discount/deductible means that the provider is reimbursed by the third party for the charges made, less the amount of the deductible specified in the policy. The provider must collect the deductible portion from the client.

In the periodic interim payment, the third party makes periodic payments for services related to a single illness or injury over the course of treatment. Here, payments are made on an ongoing basis to cover continued treatment or services rather than a single lump sum at the completion of treatment. This method is normally used only in cases of long-term treatment.

Basic Issues and Questions

There are several key questions concerning billing systems:

Who was the client? It is important that the billing personnel have reasonable knowledge of the characteristics of the client so that both specific (individual) and general (population) information about third party reimbursements may be ascertained. For example, if a majority of the clients are Medicaid enrollees, then it is helpful if the billing and collection office maintains a close relationship with the state Medicaid office.

What services were provided? An effective service-data collection system will account for all services rendered in a program no matter what the service may be. It is important that the billing system reflect the frequency of services regardless of the billing policy.

Who provided the service? The specific provider may be an issue in some jurisdictions because of state laws regarding licensure and registration of providers of health services. Through the billing system, you should be able to validate for third parties the credentials of particular individuals providing services. Usually, the names and credentials of professional providers affiliated with a program must be submitted to the third parties before bills will be processed by that third party.

What is the charge for services rendered? The program's fiscal officer will be responsible for supplying the billing office with the appropriate fee schedule for application of charges.

Is there co-insurance or deductible? The billing office must keep abreast of the status of certain plans of coverage with various third parties. Failure to collect a deductible or a co-insurance amount from the client while he is on-site may result in lost revenue to the program. All information regularly received from participating third parties should be maintained in an easily accessible place for reference on questions of deductibles and co-insurance.

Is any special billing information or form required? The billing office should request from each participating third party a supply of any and all forms necessary to properly bill for services provided to covered clients. In some instances, special forms may be requested from the program, the client, or both. The American Medical Association has developed a uniform claim form that many private insurors have adopted or modified to meet their specific needs. (Figure 7.1)

Billing Procedure Guidelines

There are certain qualities to be expected of a good billing system:

Accuracy -- There is little excuse for errors in charges or balance due.

Timeliness -- There should not be an excessive delay between the time services are provided and the date of billing.

Information -- The bill should be as explicit as possible about the encounter, indicating date of service, description of service, to whom the bill is addressed, and any other pertinent information.

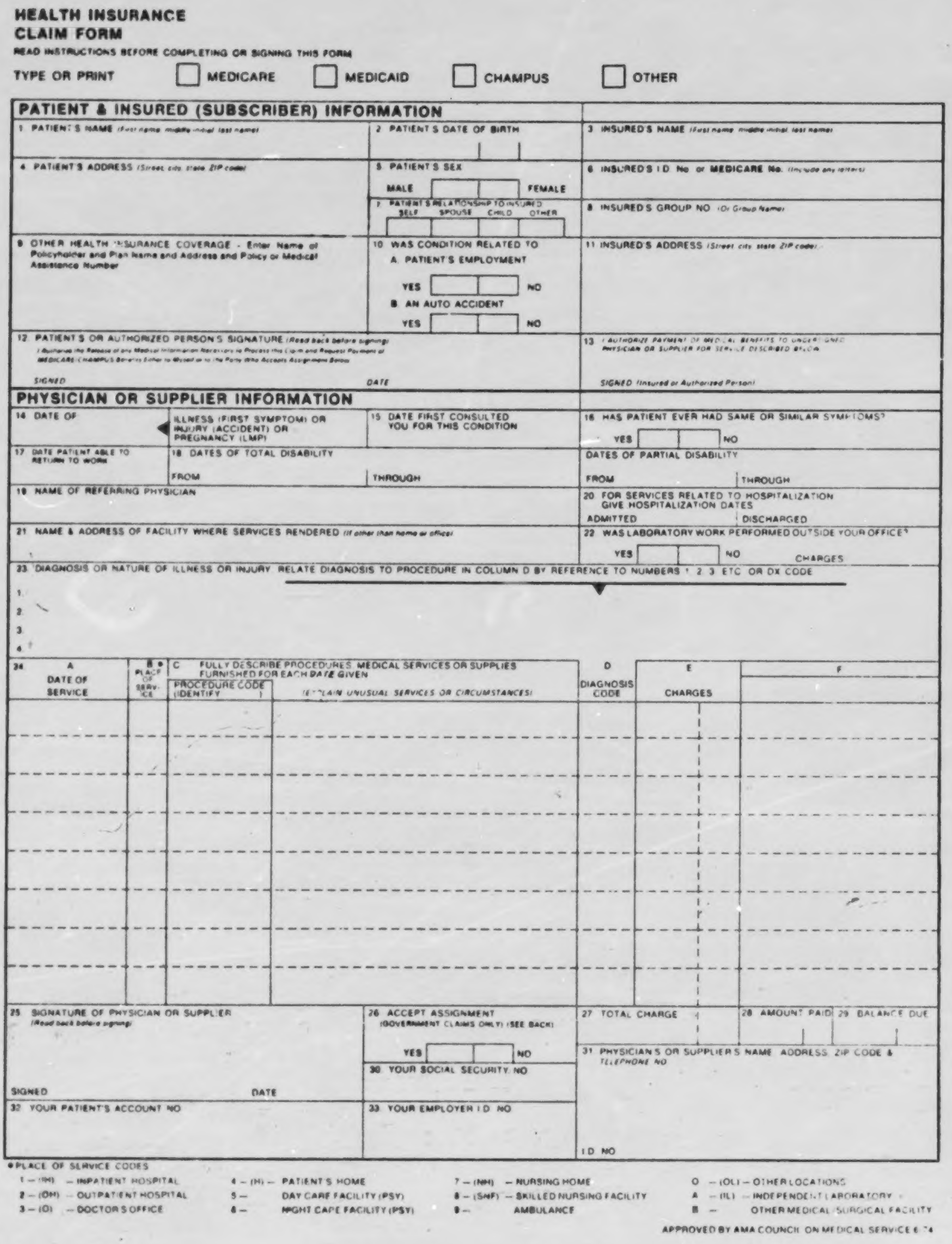
Format -- The physical appearance of the bill is important. It should represent a businesslike approach and be printed in language that the client will understand.

Terminology -- All terms used must be understood by and acceptable to third party payers.

Bill Preparation Process

A bill should be clear and concise and contain all of the information that will be needed by the client and his insurance company. Figure 7.2 is an example of a complete bill.

Item 1 on this bill is the name, address, and telephone number of the program. Item 2 is the inside address, which contains the name and address of the party responsible for the bill. This is not necessarily the person for whom services were performed. In the case of a minor, a parent or legal guardian would be responsible. Item 3 is the date the bill was prepared. The client's name (item 4) may be different from the name of the responsible party and will clarify matters if more than one family member is undergoing treatment. Item 5 is a list of the services rendered



HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

TYPE OR PRINT ☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ OTHER

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME *(First name, middle initial, last name)*
2 PATIENT'S DATE OF BIRTH
3 INSURED'S NAME *(First name, middle initial, last name)*
4 PATIENT'S ADDRESS *(Street, city, state, ZIP code)*
5 PATIENT'S SEX MALE ☐ ☐ FEMALE
6 INSURED'S I.D. No. or MEDICARE No. *(Include any letters)*
7 PATIENT'S RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐
8 INSURED'S GROUP NO. *(Or Group Name)*
9 OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number
10 WAS CONDITION RELATED TO
A. PATIENT'S EMPLOYMENT YES ☐ ☐ NO
B. AN AUTO ACCIDENT YES ☐ ☐ NO
11 INSURED'S ADDRESS *(Street, city, state, ZIP code)*
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE *(Read back before signing)*
I Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE/CHAMPUS Benefits Either to Myself or to the Party Who Accepts Assignment Below
SIGNED *DATE*
13 *I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW*
SIGNED (Insured or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ◀ ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15 DATE FIRST CONSULTED YOU FOR THIS CONDITION
16 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ ☐ NO
17 DATE PATIENT ABLE TO RETURN TO WORK
18 DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
19 NAME OF REFERRING PHYSICIAN
20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
21 NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*
22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ ☐ NO CHARGES
23 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE
1.
2.
3.
4.

24 A DATE OF SERVICE	B • PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY)	*(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)*	D DIAGNOSIS CODE	E CHARGES	F

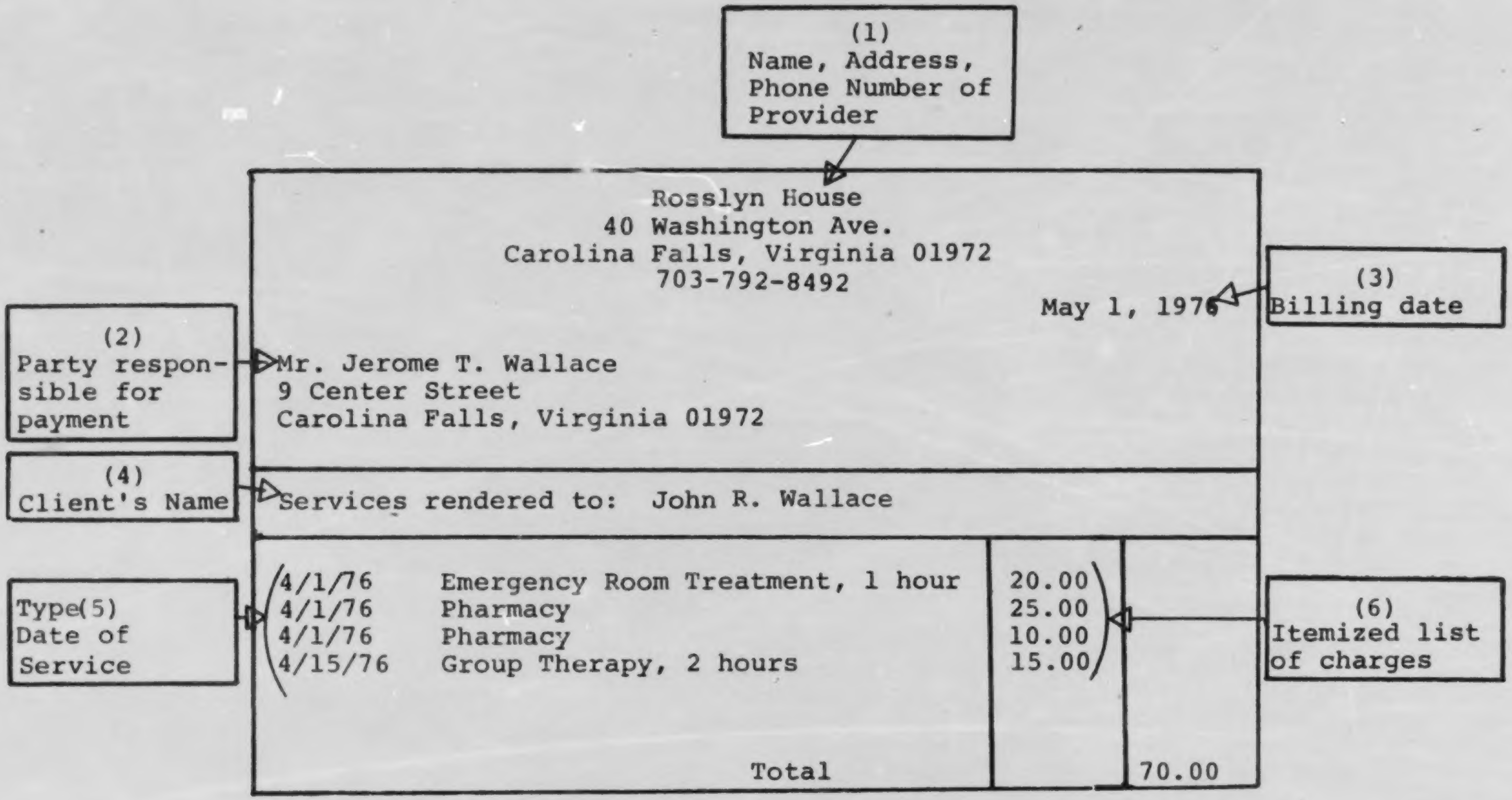
25 SIGNATURE OF PHYSICIAN OR SUPPLIER *(Read back before signing)*
SIGNED DATE
26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES ☐ ☐ NO
27 TOTAL CHARGE
28 AMOUNT PAID
29 BALANCE DUE
30 YOUR SOCIAL SECURITY NO.
31 PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & *TELEPHONE NO.*
I.D. NO.
32 YOUR PATIENT'S ACCOUNT NO.
33 YOUR EMPLOYER I.D. NO.

• PLACE OF SERVICE CODES

1 – (IH) – INPATIENT HOSPITAL	4 – (H) – PATIENT'S HOME	7 – (NH) – NURSING HOME	O – (OL) – OTHER LOCATIONS
2 – (OH) – OUTPATIENT HOSPITAL	5 – DAY CARE FACILITY (PSY)	8 – (SNF) – SKILLED NURSING FACILITY	A – (IL) – INDEPENDENT LABORATORY
3 – (O) – DOCTOR'S OFFICE	6 – NIGHT CARE FACILITY (PSY)	9 – AMBULANCE	B – OTHER MEDICAL/SURGICAL FACILITY

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6-74

Figure 7.1 Uniform Claim Form developed by the American Medical Association


(1)
Name, Address, Phone Number of Provider
(2)
Party responsible for payment
(3)
Billing date
(4)
Client's Name
Type(5)
Date of Service
(6)
Itemized list of charges

Rosslyn House
40 Washington Ave.
Carolina Falls, Virginia 01972
703-792-8492

May 1, 1976

Mr. Jerome T. Wallace
9 Center Street
Carolina Falls, Virginia 01972

Services rendered to: John R. Wallace

4/1/76	Emergency Room Treatment, 1 hour	20.00	
4/1/76	Pharmacy	25.00	
4/1/76	Pharmacy	10.00	
4/15/76	Group Therapy, 2 hours	15.00	
	Total		70.00

Figure 7.2 Sample Bill for Services

Jerome Wallace
9 Center Street
Carolina Falls, Virginia 01972

Client: John Wallace

		Charges	Balance
4/1/76	Initial Evaluation	20.00	
4/1/76	Physical Examination	25.00	
4/1/76	Urinalysis	10.00	
4/15/76	Group Therapy, 2 hours	15.00	
			70.00
5/1/76	Billed Federated Mutual		
7/1/76	Payment: Federated Mutual	50.00	20.00
7/15/76	Billed client	20.00	20.00
8/1/76	Payment: Client	10.00	10.00

Figure 7.3 Sample Master Ledger Sheet

and the dates on which they were given. Item 6 is the charge made for each of the services provided.

You can facilitate bill preparation with a master ledger sheet showing, for each client, amounts owed, amounts paid, date and amount of claims sent to third parties, and results of claims (see Figure 7.3). Standard forms are available for this purpose and are designed to be photocopied to save typing a bill.

Some Billing Caveats

Classify Services by Categories; Use Acceptable Terminology

When dealing with third party payers, you should communicate with them in language that they understand. It is doubtful, for example, that a diagnosis of a "bad trip" would be considered appropriate. Administration of methadone, naloxone, or other blocking drugs can be billed as pharmacy charges or drug therapy. The care of resident clients can be classed under room charges. Detoxification or care of overdose victims, if you are equipped for this, is emergency service. Rap sessions might be covered as group therapy under those policies providing for psychiatric care.

Remember that every discipline, whether journalism or aerospace engineering, has its own nomenclature and that the jargon used in one field is completely foreign to those who work in another. The terminology of data processing is incomprehensible to a dietician, and the street talk of the drug world is probably equal gibberish to an insurance clerk.

The issue of terminology is also important when dealing with any of the governmental third party payers. Not only is the claim procedure sometimes more rigid, but the acceptable terms may be more limited.

There are books available that can help you in the use of proper terminology, for example: Paramedical Dictionary by J. E. Schmidt, M.D.; Understanding Medical Terminology by Sister Mary Agnes Clare Frenay, S.S.M. (the fifth edition has a section on drug addiction); and Uniform Hospital Definitions by the American Hospital Association, which deals with units and measurements and is partially aimed at third party payers.

Separate Covered Elements from Uncovered Ones

Even the most liberal insurance plan will not cover all of the services you may provide in your center. For instance, job placement, vocational rehabilitation, or outreach programs may not be billed to insurance companies or other third party payers. Similarly, a counseling session might be covered if conducted in the center, but not if it takes place in the streets or over the phone.

To keep operations legitimate in the eyes of third parties, to protect yourself during auditing, and to formalize your own accounting procedures, you must keep charges that are covered (room charges, pharmacy, etc.) separate from those that are not. For example, a two-hour session that is partially group therapy but mostly vocational rehabilitation must be broken down clearly into segments, as one may be covered treatment and the other not. The best procedure would be to break the session into two distinct parts, one devoted to each of the above services. Staff time should be broken down in a similar fashion. If one staff member conducts group therapy sessions several times a day, with the rest of his time spent on the streets doing outreach, his time should be separated into two accounts.

It is often very difficult to know which program elements will be covered and which will not. Conventional establishments such as hospitals learn through experience what is likely to be covered. For example, the room charge includes the cleanup, the linens, use of water glasses, etc. These items are not accounted for or billed separately by the hospital, simply because experience has shown that they are all covered charges if the room itself is covered.

Drug abuse treatment centers have much less experience to go on as to what will be covered, making billing separations more important than in the usual hospital situation. You might even want to separate the methadone itself (pharmacy charges) from the services and disposable supplies. You certainly would want to separate group therapy from vocational rehabilitation counseling. Experience will determine the exact degree of separation that is helpful and necessary. If you start out separating elements, you can always combine them later if you find it an unnecessary task. If you start out combining components, you'll probably have a tough time separating them at a later date.

COLLECTION PROCEDURES

There should be written policies regarding the entire collection process including strategies for collecting outstanding indebtedness and dealing directly with paying clients. This is particularly important due to the "cash flow" problem inherent in a third party payments system. That is, services are provided and costs are incurred in providing these services (staff salaries, supplies, rent, etc.) before payment is received. This situation is in direct contrast to the grant system, in which monies are received prior to providing services.

Collection Policy

There should be a written collection policy that will address the following basic issues:

- When an account should be followed up
- How the follow-up will be accomplished
- Who should do the follow-up
- Who decides that an account is uncollectible

Follow-up

A copy should be kept of all claims submitted to third party payers. Follow-up on these claims may be necessary due to delays in receiving reimbursement. Payment of a claim may be delayed for a reason as simple as a mistyped policy number or a misspelled policyholder's name, or as serious as a question about the eligibility of the service itself or your program's legitimacy.

All follow-up should be conducted by letter in order both to formalize the inquiry and to provide a record of the action taken. Your letter should include all pertinent information to help the third party locate your claim. The most important items to include are: (1) the claim number (from the claim form), (2) the policy and/or group number, (3) the date on which you sent the claim, (4) the name of the insured party (not necessarily the client), (5) the person served, (6) his status--inpatient or outpatient--(there may be different departments to handle each type of claim), and (7) the dates services were given.

Collection procedures are a necessary part of a third party payment system that can and should function in a nonthreatening manner and serve as the final step in the system.

SESSION 8

PROGRAM/SSA PLANNING

8

SESSION 8

LEARNING OBJECTIVES

Participants will consider the planning necessary for obtaining and maximizing third party payments.

At the end of this session the local program participants will complete Workshop Packet W-3, Project Planning, according to the instructions of the trainer.

At the end of this session the SSA participants will complete Workshop Packet W-4, SSA Planning, according to the instructions of the trainer.

SESSION: 8

SESSION REQUIREMENTS	
PERSONNEL	Trainer (for the introducation only)
TIME	2 hours
EQUIPMENT	None
MATERIALS	Workshop Packets (1 packet per trainee) (Appendix 1) W-3: Project Planning W-4: SSA Planning
FACILITY	Large-group meeting room Work areas (3 to 4 trainees per area)

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Session 8: PROGRAM/SSA PLANNING

TIME/ FORM	MATERIALS & EQUIPMENT/ REFERENCES	ACTIVITIES
5 min. LG M-L		INTRODUCTION
		● Mention that this session will involve individual and small-group study and discussion.
1 hr. 15 min SG/I		WORKSHOP
		● Divide trainees into small groups of three to four members with SSA representatives separate from program administrators. *(It may be advisable to separate program administrators by type of treatment modality, e.g., therapeutic community, methadone clinics, etc.)*
	Workshop Packets W-3, W-4	● Distribute workshop packets.
		● Ask SSA representatives to list specific actions that will assist local programs in obtaining and maximizing third party payments.
		● Ask program administrators to list specific information they need to determine the feasibility of obtaining third party payments.
		● Ask individuals to discuss their lists within their groups and then revise their lists putting items in order of priority. Priorities should then be discussed within the group.
10 min. LG D		DISCUSSION
		● Ask participants whether they are satisfied with the beginning of their planning.
		● Ask for recommendations that might assist those having difficulty in their planning.
		● Answer any questions.
30 min.		POSTTEST
	Posttest	● Administer posttest.

APPENDICES

A

APPENDIX 1
WORKSHOP PACKETS

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APPENDIX 1-1

Workshop W-1

Note to Reader:

This appendix contains forms to be used in conducting workshop sessions and are referenced in the instructions for the various workshops.

In the final version of the Trainer's Manual, these materials will appear following the trainer instructions for the relevant sessions.

MEDICAID ASSESSMENT FORM

NOTE: Using the State Medicaid Chart for your State (Appendix B of the Trainee Handbook) and your knowledge of your own program, complete the following questionnaire.

1. Will some (or all) of my clients meet the eligibility criteria established by my State? Yes___ No___ Need to Determine___

2. Are any of my clients already certified for Medicaid? Yes___ No___ Need to Determine___

3. Do I have a clear understanding of the provider eligibility criteria for Medicaid in my state? Yes___ No___

4. Does my program meet the provider eligibility criteria for Medicaid in my State? Yes___ No___ Need to Determine___

[illegible]. Would it be possible for my program to meet the provider eligibility criteria? Yes___ No___ Need to Determine___

6. Are the type of services provided by my program covered by Medicaid in my State? Yes___ No___ Need to Determine___

7. Is my program in a position to carry out the necessary processes required to become certified by Medicaid? Yes___ No___ Need to Determine___

8. Analyze the "Remarks" section of the State Medicaid Chart for your State and ask yourself whatever questions you can think of as a result of your analysis.

9. On the back of this sheet, list those things which you must do upon returning to your program which will result in obtaining satisfactory (to you) answers to the "Need to Determine" items above.

TITLE XX ASSESSMENT FORM

NOTE: Using the Title XX Chart for your State (Appendix C of the Trainee Handbook) and your knowledge of your program, complete the following questionnaire.

1. Does title XX cover services to addicts, in my State? Yes___ No___

2. Does my program provide services covered under title XX in my State? Yes___ No___ Need to Determine___

3. Which of those services covered does my program provide?

   a. ______________________________

   b. ______________________________

   c. ______________________________

   d. ______________________________

4. Will some (or all) of my clients meet the eligibility criteria established in my State? Yes___ No___ Need to Determine___

5. If services to addicts are not statewide in my State, does my program fall within the covered area? Yes___ No___ Need to Determine___

6. Do I know the requirements for a Purchase of Services Agreement with my State's title XX agency? Yes___ No___

7. On the back of this sheet, list those things which you need to do upon returning to your program which will result in obtaining satisfactory (to you) answers to all of the above questions.

PAYER PRIORITY LIST

Directions

1. Study the list of third party payers in the left column.
2. Determine which of these have a relatively high potential as possible sources for reimbursement for your program. Indicate these by an "X" in the middle column.
3. Determine which of the remaining payers have a relatively low potential for (but are still possible sources of) reimbursement for your program. Indicate these by an "X" in the last column.
4. Determine (estimate) the relative potential of each of the indicated payers as a source of reimbursement for your program. Indicate this by assigning a number to each of the "X's" ("1" designating the highest potential, "2" the next highest, etc.

PAYERS	HIGH POTENTIAL	LOW POTENTIAL
Medicaid		
Medicare		
Title XX		
CHAMPUS		
Food Stamps		
Vocational Rehabilitation		
Private Insurance Companies		
Health Maintenance Organizations		

APPENDIX 1-2

Workshop W-2

PAYER PRIORITY LIST

Directions

1. Study the list of third party payers in the left column.
2. Determine which of these have a relatively high potential as possible sources for reimbursement for your program. Indicate these by placing an "X" in the middle column.
3. Determine which of the remaining payers have a relatively low potential for (but are still possible sources of) reimbursement for your program. Indicate these by an "X" in the last column.
4. Determine (estimate) the relative potential of each of the indicated payers as a source of reimbursement for your program. Indicate this by assigning a number to each of the "Xs" ("1" designating the highest potential, "2" the next highest, etc.).

PAYERS	HIGH POTENTIAL	LOW POTENTIAL
Medicaid		
Medicare		
Title XX		
CHAMPUS		
Food Stamps		
Vocational Rehabilitation		
Private Insurance Companies		
Health Maintenance Organizations		

APPENDIX 1-3

Workshop W-3

PROGRAM PLANNING WORKSHOP

The purpose of this workshop is to identify and set priorities for obtaining information you must have in order to determine the feasibility of your program's being eligible for third party payments.

There are four tasks to be performed. Descriptions of each are given below. Forms to be used for tasks 1, 3, and 4 are attached.

TASK 1 (15 minutes)

This task is to be done individually.

On the accompanying sheet, list the specific information you will need to obtain before your program can decide whether it is feasible to receive third party payments.

Try to be as comprehensive and specific as possible. For example, instead of merely noting "find out about Medicaid," list specific items of information (e.g., provider eligibility criteria for your state's program, nature of "rehabilitative services" covered).

Feel free to use your Trainee Handbook and your notes.

TASK 2 (20-30 minutes)

Discuss your list with your group to determine:

a) Whether each item on your list is clear in terms of what you need to know; and

b) Whether your list is comprehensive.

250

TASK 3 (10 minutes)

This task is to be done individually.

a) Revise your list if appropriate, based on group comments.

b) On the accompanying sheet, establish priorities for your list. Force yourself to rank each item in order of importance. Do not assign the same ranking to more than one item.

TASK 4 (30 minutes)

With the help of your group, analyze the items on your priority list and for each one determine what will have to be done (and by whom) in order to obtain that information. Use accompanying sheet to record what needs to be done and who will do it.

TASK 1

Specific information needed in order to determine the feasibility of my program's obtaining third party payments.

List:

TASK 2

Discuss your list with your group.

TASK 3

PRIORITIES

1.

2.

3.

4.

5.

253

TASK 4

For each of your first five priorities, list what needs to be done and who will do it.

Priority 1:

What to do	Who will do

Priority 2:

What to do	Who will do

TASK 4 (continued)

Priority 3:

What to do Who will do

Priority 4:

What to do Who will do

Priority 5:

What to do Who will do

APPENDIX 1-4

Workshop W-4

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SSA PLANNING WORKSHOP

The purpose of this workshop is to identify and set priorities for actions that your agency should take in order to assist drug abuse treatment programs in your state in obtaining third party revenues.

There are four tasks to be performed. Descriptions of each are given below. Forms to be used for Tasks 1 and 3 are attached.

TASK 1 (15 mins.)

This task is to be performed individually.

On the accompanying sheet, develop a list of things your SSA can do to assist drug abuse treatment programs in your state in obtaining third party payments. Be as specific as possible. Try to limit yourself to activities for the near future.

TASK 2 (20-30 mins.)

Discuss your list with your group in order to:

1) Make sure each item is specific and realistic; and

2) Decide if your list is comprehensive.

TASK 3 (10 mins.)

This task is to be performed individually.

1) If appropriate, revise your list based on your group's comments.

2) On the accompanying sheet, establish priorities for the items on your list. Force yourself to rank each item in order of importance. Do not assign the same ranking to more than one item.

3) On the accompanying sheet, begin a list of steps that need to be taken for the first four priority items. Indicate who will be responsible for each step.

TASK 4 (30 mins.)

With the help of your group, analyze the items on your priority list and for each one determine what will have to be done (and by whom) in order to obtain that information. Use accompanying sheet to record what needs to be done and who will do it.

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TASK 1

List actions to be taken to assist local programs in obtaining third party payments. (Be specific and try to limit yourself to the near future.)

TASK 2

Discuss your list with your group.

TASK 3

Priorities

1.

2.

3.

4.

5.

260

TASK 4

For each of your first four priorities, list what steps need to be taken and who will be responsible.

Priority 1:

Steps to take	Responsibility

Priority 2:

Steps to take	Responsibility

Priority 3:

Steps to take	Responsibility

Priority 4:

Steps to take	Responsibility

Priority 5:

Steps to take	Responsibility

APPENDIX 2
TEST FORMS A & B

TEST FORM A

Please circle the letter on your answer sheet corresponding to the single best answer to each question:

1. Which of the following is NOT a reason for attempting to collect third party payments:

   A. Expansion or improvements in a program.
   B. Preparation for participation of drug abuse programs in any future national health insurance program.
   C. Protection against cutbacks in other funding sources.
   D. Simplified financial planning.
   E. Improved program credibility.

2. The best example of third party payments is where:

   A. Payment is made by Blue Shield to a residential treatment center.
   B. Payment is made by the drug addict to his private physician for drug abuse treatment.
   C. Payment is made by the drug addict to a methadone clinic for his maintenance treatments.
   D. Payment is not demanded of the drug addict because he is being treated in a free clinic.
   E. Payment is made by a state Medicaid agency to a methadone maintenance program.

3. The Health Services Funding Regulations effective January 1, 1974, indicate that HEW is:

   A. Being pressured by private insurance companies to limit third party payments.
   B. Delaying any action regarding third party payments.
   C. Encouraging drug abuse treatment facilities to actively seek third party payments.
   D. Preparing to expand its role in support of drug abuse programs.
   E. Being pressured by private insurance companies to expand public funding for third party payments.

4. Which of the following is the most important factor in obtaining third party reimbursement for a drug abuse program:

   A. Client eligibility
   B. Provider eligibility
   C. Service eligibility
   D. All of the above
   E. None of the above

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5. If your insurance policy requires that you pay 15% of the cost of treatment, your policy is classified as:

   A. Coinsurance
   B. Comprehensive insurance
   C. Deductible insurance
   D. Payment insurance
   E. Pre-payment plan

6. In investigating whether a client is eligible for medical coverage, a conversion privilege to an individual policy is likely when:

   A. The client has just been honorably discharged from the military.
   B. The client has recently been fired from his job.
   C. The client is eligible for Medicaid.
   D. All of the above.
   E. None of the above.

7. Which one of the potential third party payers listed below is most likely to provide payment to drug abuse treatment programs?

   A. Blue Cross/Blue Shield
   B. Health Maintenance Organizations
   C. Medicare
   D. CHAMPUS
   E. Medicaid

8. Which of the following Medicaid services must be provided to eligible clients in every state?

   A. Diagnostic, preventitive and rehabilitative services
   B. Drugs, dentures, and eyeglasses
   C. Outpatient hospital services
   D. All of the above
   E. None of the above

9. To achieve or maintain self-sufficiency is a major goal of:

   A. CHAMPUS
   B. Food stamp program
   C. Title XX
   D. Vocational Rehabilitation
   E. Medicaid

10. A formal written agreement is required for reimbursement to a provider except for:

    A. CHAMPUS
    B. Medicaid
    C. Title XX
    D. Vocational Rehabilitation
    E. None of the above

11. Which of the following individuals is eligible for Medicaid?

    A. Anyone whose income is below the federally established maximum.
    B. Anyone who has been a resident of the state for at least three months.
    C. Anyone who has been unable due to disability to work for at least six months.
    D. Dependents of AFDC recipients.
    E. All of the above.

12. If a significant proportion of a program's clients are dependents of military personnel, a potential third party payer would be:

    A. CHAMPUS
    B. Department of Defense
    C. Medicare
    D. Veterans Administration
    E. Public Health Maintenance Organization (HMO)

13. Title XX of the Social Security Act (Grants to States for Services) allows each state to determine:

    A. What services will be made available
    B. Where and how services will be provided
    C. Who will be eligible for services
    D. Both A and B
    E. A, B and C above

14. The factor most commonly used by private insurance companies in determining provider eligibility is:

    A. Accreditation
    B. Certification
    C. State licensure
    D. Credentialing
    E. Type of services offered

The following charts are to be used in answering questions 15-17, all of which pertain to Title XX (Grants to States for Services).

Table of Income Levels -- Family of Four

State	Median	80% of Median	115% of Median
Alabama	11,790	9,432	13,559
Alaska	17,223	13,778	19,806
Arizona	13,917	11,134	16,005
Arkansas	11,195	8,956	12,874
California	14,778	11,822	16,995

Table of Adjustments for Various Sized Families

Number of Family Members	Equivalent Income Ceiling
1	52%
2	68%
3	84%
4	100%
5	116%
6	132%

For each additional family member over 6, add 3% to the income ceiling for a family of 6.

15. At what income level does a family of four become ineligible for services under Title XX in Alaska?

A. 13,778
B. 17,223
C. 19,806
D. 8,612
E. None of the above

16. For a family of four, at what level must a fee for services be imposed in Alabama under Title XX?

A. 9,432
B. 11,496
C. 11,790
D. 13,559
E. None of the above

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17. What is the maximum income level for eligibility under Title XX for a family of three in Arizona?

A. 9,352
B. 11,690
C. 13,444
D. 16,005
E. None of the above

18. Individuals who are substance abusers, under the 1973 Vocational Rehabilitation Act, are:

A. Automatically classified as "severely disabled."
B. Not included under any of the "severely disabled" categories.
C. Unable to meet the criteria allowing them to be classified as "severely disabled."
D. Both B and C.
E. None of the above.

19. The Health Maintenance Organization Act of 1973 requires that:

A. New or expanding HMOs seeking federal assistance must make drug abuse treatment services available to its members.
B. Any HMO receiving any federal funding must offer drug abuse treatment services to its members.
C. All HMOs employing 25 or more people, must offer substance abuse treatment services to its members.
D. HMOs may contract for services with drug treatment programs as long as the program determines client and provider eligibility.
E. None of the above.

20. When determining service eligibility (services covered) the most important thing a treatment facility should remember is that:

A. Federal service eligibility criteria supersede state criteria.
B. Each state has service eligibility that are specific to that state.
C. The service eligibility criteria of private payers are independent of state but not federal criteria.
D. State service eligibility criteria supersede both federal and private payer criteria.
E. All of the above.

21. Cost accounting techniques are appropriately used to:

A. Analyze patterns of service utilization.
B. Control cash flow.
C. Identify program planning assumptions.
D. Quantify objectives for program management.
E. Perform all of the above.

22. Among many reasons for having a published fee schedule in a treatment program, the LEAST significant is:

A. To ensure a standard charge for a given service.
B. To enable the client to estimate how much he will be charged.
C. To assure that the provider is compensated for services rendered.
D. To meet a basic requirement of third party payers.
E. None of the above.

23. A facility that establishes treatment charges for individuals on the basis of their ability to pay is said to have:

A. A flexible rate plan.
B. A sliding fee schedule.
C. Variable cost indexing.
D. A variable fee for service plan.
E. None of the above.

24. Given the following hypothetical (and oversimplified) cost structure for a program:

Counseling cost - $9,000
Emergency Care - $8,000
Residential care - $7,000
Vocational training - $6,000
Indirect costs - $5,000
Total cost $35,000

What proportion of indirect costs might reasonably be added to counseling costs in determining costs for counseling?

A. 5,000 / 35,000 (about 14%)
B. 5,000 / 9,000 (about 55%)
C. 9,000 / 35,000 (about 26%)
D. 9,000 / 26,000 (about 35%)
E. None of the above

25. Which of the following is an indirect cost?

A. Counselors' salaries
B. Charges of a consulting psychiatrist
C. Lab fees
D. Treatment center secretary
E. None of the above

The remaining items are True or False. Circle the appropriate letter (T or F) on your response sheet.

26. Efforts to remove legislative barriers to obtaining provider status with a third party payer should be described in meeting the reporting requirements of the Health Service Funding Regulations.

27. A treatment program that receives food under the Surplus Food Program is automatically eligible for food stamps if its residents also meet eligibility requirements.

28. Group policies are much less likely than individual policies to provide payments for drug addiction.

29. When state laws regarding the confidentiality of client records differ substantially from the federal regulations, they should supersede the federal regulations.

30. A drug abuse treatment program is compelled to disclose client information if served with a court order issued under the federal confidentiality regulations.

THIRD PARTY PAYMENTS

FORM A

To mark your response, blacken the appropriate letter. If you make a mistake, completely *erase the incorrect answer.*

1. A B C D E
2. A B C D E
3. A B C D E
4. A B C D E
5. A B C D E
6. A B C D E
7. A B C D E
8. A B C D E
9. A B C D E
10. A B C D E
11. A B C D E
12. A B C D E
13. A B C D E
14. A B C D E
15. A B C D E
16. A B C D E
17. A B C D E
18. A B C D E
19. A B C D E
20. A B C D E
21. A B C D E
22. A B C D E
23. A B C D E
24. A B C D E
25. A B C D E
26. T F
27. T F
28. T F
29. T F
30. T F

TEST FORM B

Please circle the letter on your answer sheet corresponding to the single best answer to each question:

1. Which of the following is NOT a reason for attempting to collect third party payments?

   A. Improved program credibility.
   B. Preparation for participation in any future national health insurance program.
   C. Reduced dependency on a single funding source.
   D. Simplified financial planning.
   E. Program expansion or improvement.

2. The best example of a third party payment for drug abuse treatment is where:

   A. The addict pays his private physician for treatment.
   B. Blue Shield pays a residential treatment center for care of a client.
   C. A clinic provides free care to a destitute addict.
   D. A foundation provides a treatment grant to a residential treatment center.
   E. Medicaid makes direct payment to a physician for services provided to a client who is a recipient of public assistance under the AFDC program.

3. The federal government serves as the primary third party payment source for:

   A. SSI recipients
   B. Military dependents
   C. Public service employees
   D. Both A and B above
   E. A, B, and C above

4. A drug abuse treatment program may refuse treatment to:

   A. Anyone unable to pay for services by some means.
   B. Anyone ineligible for third party payment assistance.
   C. Anyone who does not reside in the state where the program is located.
   D. All of the above.
   E. None of the above.

5. The procedure for determining a client's eligibility for third party payments is best described as:

   A. An information gathering and review function of a designated staff member.
   B. The responsibility of the client as assisted by the program's staff.
   C. A function of the state and federal agencies providing program funding.
   D. Helping the client apply for assistance from a variety of potential third party payers.
   E. None of the above.

6. Obtaining information relevant to determining a client's eligibility for third party reimbursement is a task most appropriately assigned to the:

   A. Client's individual counselor
   B. Insurance claims specialist
   C. Treatment center intake counselor
   D. Treatment center receptionist
   E. None of the above

7. A client who signs a release permitting his insurance company to pay a service provider directly has used which method of reimbursement:

   A. Benefit waiver
   B. Deductible reimbursement
   C. Direct reimbursement
   D. Periodic interim payment
   E. Assigned allowance

8. If your insurance policy requires that you pay the first $500 of the cost of treatment, your policy is most properly classified as:

   A. Coinsurance
   B. Comprehensive insurance
   C. Deductible insurance
   D. Payment insurance
   E. Pre-payment plan

9. The factor most commonly used by private insurance companies in determining provider eligibility is:

   A. Accreditation
   B. State licensure
   C. Treatment success rate
   D. Types of services offered
   E. Certification

10. When determining service eligibility under Medicaid, the most important thing to remember is that:

A. Federal service eligibility criteria supersedes state criteria.
B. Private payers can set eligibility criteria independently of state but not federal criteria.
C. State service eligibility criteria supersedes federal criteria.
D. Each state sets its own criteria for services.
E. All of the above.

11. States have the greatest latitude in determining who is eligible for services under:

A. CHAMPUS
B. Medicare
C. Medicaid
D. Title XX
E. Vocational Rehabilitation

12. To achieve or maintain economic self support so as to prevent, reduce or eliminate dependency is a goal of:

A. CHAMPUS
B. Food Stamp program
C. Medicaid
D. Title XX
E. Vocational Rehabilitation

13. Which of the following services may be offered at the option of a state in addition to required services, under Medicaid?

A. Clinic services
B. Family Planning services
C. Physicians services
D. Transportation to and from service providers
E. All of the above

14. The provider eligibility criteria for drug abuse treatment programs for which of the following payers is closest to the medical model?

A. CHAMPUS
B. Blue Cross/Blue Shield of Michigan
C. Medicaid
D. The Hartford Insurance Company
E. Vocational Rehabilitation

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15. A provider can be reimbursed under Title XX (Grants to States for Services) only if it has a written contract (Purchase of Services Agreement) that must contain all but one of the following:

A. Assurance of compliance with the Civil Rights Act of 1964.
B. Protection of human subjects review procedure.
C. Specification of the location where services are to be provided.
D. The basis for and nature of the reimbursement procedure.
E. Specify requirements for financial management.

16. Coverage for drug abuse is specifically included in which one of the following proposed National Health Insurance bills?

A. Comprehensive Health Care Insurance Act of 1975 (Fulton Bill)
B. Health Security Act (Corman-Kennedy Bill)
C. National Health Care Services Reorganization and Financing Act (Ulman Bill)
D. All of the above
E. None of the above

The following charts are to be used in answering questions 17-19, all of which pertain to Title XX (Grants to States for Services).

Table of Income Levels -- Family of Four

State	Median	80% of Median	115% of Median
Alabama	11,790	9,432	13,559
Alaska	17,223	13,778	19,806
Arizona	13,917	11,134	16,005
Arkansas	11,195	8,956	12,874
California	14,778	11,822	16,995

Table of Adjustments for Various Sized Families

Number of Family Members	Equivalent Income Ceiling
1	52%
2	68%
3	84%
4	100%
5	116%
6	132%

For each additional family member over 6, add 3% to the income ceiling for a family of 6.

17. At what income level does a family of four become ineligible for services in Alabama?

A. 9,432
B. 11,790
C. 13,559
D. 19,806
E. None of the above

18. For a family of four, at what level must a fee for services be imposed in Arkansas?

A. 8,956
B. 11,195
C. 12,874
D. 5,598
E. None of the above

19. What is the maximum eligibility level for a family of 6 in California?

A. 14,778
B. 15,605
C. 19,506
D. 22,433
E. None of the above

20. Under the new federal confidentiality regulations, which of the following items IS NOT required on a written consent form?

A. Date on which consent is signed.
B. Extent or nature of information to be disclosed.
C. Purpose or need for disclosure.
D. Signature of staff member making the disclosure.
E. Date or condition upon which the consent expires.

21. Cost accounting services are most appropriate to:

A. Analyze patterns of service utilization
B. Establish the fee schedule
C. Identify program planning assumptions
D. Quantify objectives for program management
E. All of the above

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22. Which of the following is an indirect cost?

A. Counselors' salaries
B. Lab fees
C. Pharmaceuticals
D. Rent
E. None of the above

23. A facility that charges clients the same amount for a given service regardless of the ability to pay is said to have a:

A. Fixed cost accrual system.
B. Standard billing procedure.
C. Uniform charge structure.
D. Universal rate index.
E. Fee schedule.

24. Given the following hypothetical (and oversimplified) cost structure for a program:

Counseling cost	$9,000
Emergency care	$8,000
Residential care	$7,000
Vocational training -	$6,000
Indirect costs	$5,000
Total cost	$35,000

What proportion of indirect costs might reasonably be added to residential care in determining charges for counseling?

A. 5,000 / 35,000 (about 14%)
B. 5,000 / 7,000 (about 70%)
C. 7,000 / 35,000 (about 20%)
D. 7,000 / 28,000 (about 25%)
E. None of the above

25. Generally, the most acceptable accounting system:

A. Recognizes income when a client receives a service.
B. Recognizes income when a bill for service is presented to a client.
C. Recognizes income when a check is received from a client.
D. Recognizes income when a check clears the bank and is actually deposited.
E. Does all of the above.

The following questions are True or False. Circle the appropriate letter (T or F) on your response sheet.

26. Mutual insurance companies are much more likely to provide coverage for drug addiction than are stock companies.

27. Outpatient hospital services are among those mandated by Medicaid for drug abuse patients.

28. Substance abuse is specifically listed as a severely disabling condition under Vocational Rehabilitation.

29. Federal confidentiality regulations specifically apply to any institution which has been given tax exempt status by the Internal Revenue Service.

30. Disclosure of client information to medical personnel are authorized without patient consent if a genuine medical emergency exists and the information is needed for diagnosis and treatment.

THIRD PARTY PAYMENTS

FORM B

To mark your response, blacken the appropriate letter. If you make a mistake, completely *erase the incorrect answer.*

1. A B C D E
2. A B C D E
3. A B C D E
4. A B C D E
5. A B C D E
6. A B C D E
7. A B C D E
8. A B C D E
9. A B C D E
10. A B C D E
11. A B C D E
12. A B C D E
13. A B C D E
14. A B C D E
15. A B C D E
16. A B C D E
17. A B C D E
18. A B C D E
19. A B C D E
20. A B C D E
21. A B C D E
22. A B C D E
23. A B C D E
24. A B C D E
25. A B C D E
26. T F
27. T F
28. T F
29. T F
30. T F

THIRD PARTY PAYMENTS

ANSWER KEY

FORM A

1. A B C ● E
2. A B C D ●
3. A B ● D E
4. A B C ● E
5. ● B C D E
6. A ● C D E
7. A B C D ●
8. A B ● D E
9. A B ● D E
10. A B C ● E
11. A B C ● E
12. ● B C D E
13. A B C D ●
14. ● B C D E
15. A B ● D E
16. ● B C D E
17. A B ● D E
18. A ● C D E
19. ● B C D E
20. A ● C D E
21. A ● C D E
22. A B ● D E
23. A ● C D E
24. A B ● D E
25. A B C ● E
26. ● F
27. T ●
28. T ●
29. T ●
30. T ●

THIRD PARTY PAYMENTS

ANSWER KEY

FORM B

1. A B C ● E
2. A B C D ●
3. A B C ● E
4. A B C D ●
5. ● B C D E
6. A ● C D E
7. ● B C D E
8. A B ● D E
9. ● B C D E
10. A B C ● E
11. A B C ● E
12. A B C ● E
13. ● B C D E
14. ● B C D E
15. A ● C D E
16. A ● C D E
17. A B ● D E
18. ● B C D E
19. A B ● D E
20. A B C ● E
21. A ● C D E
22. A B C ● E
23. A B ● D E
24. A B ● D E
25. ● B C D E
26. T ●
27. T ●
28. T ●
29. ● F
30. ● F

APPENDIX 3
ADDITIONAL REFERENCES AND RESOURCES

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ADDITIONAL REFERENCES AND RESOURCES

Third-Party Reimbursement. Report Series 35 Issue C. A series of documents dealing with various topics related to third-party payments, available free of charge from:

National Clearinghouse for Drug Abuse Information
P. O. Box 1635
Rockville, MD 20850

Regulations and Guidelines for Health Services Funding. Available free of charge from:

National Clearinghouse for Drug Abuse Information
P. O. Box 1635
Rockville, MD 20850

Confidentiality of Alcohol and Drug Abuse Patient Records, General Provisions. Federal Register, July 1, 1975, beginning on page 27802.

Title XX Regulations. Federal Register, June 27, 1975, page 27352.

All additions or corrections to regulations and newly published regulations are presented in the Federal Register. It is available at $.15 per page or $.75 for a complete issue from:

National Archives Building
Office of the Federal Register
8th Street and Pennsylvania Avenue, N.W.
Washington, DC 20408

A Citizen's Handbook: Social Services '75. Reference SRS 75-23038. This document provides a quick and easy reference to title XX and may be obtained without charge from:

Community Services Administration
Social and Rehabilitation Service
Department of Health, Education, and Welfare
330 C Street, S.W.
Washington, DC 20201

The Social Security Act (As Amended Through January 4, 1975) and Related Laws. Reference Number Y4.F49:S01/39, $5.80, available from:

Superintendent of Documents
U.S. Government Printing Office
Washington, DC 20402

1974 Social Security and Medicare Explained--Including Medicaid. This document provides a general, easy to understand explanation of the Medicare and Medicaid programs and is available for $5.00 from:

The Commerce Clearinghouse, Inc.
4025 W. Peterson Avenue
Chicago, IL 60646

Standards for Drug Abuse Treatment and Rehabilitation Programs. Available for $7.50 from:

Joint Commission on Accreditation of Hospitals
875 North Michigan Avenue
Chicago, IL 60611

Confidentiality of Alcohol and Drug Abuse Patient Records - A Self-Paced Programmed Instructional Course. Available for $5.50 from:

National Drug Abuse Center
1901 North Moore Street
Arlington, VA 22209

Private Third Party Reimbursement. Topics in Health Care Financing, 2(1). Available from Aspen Systems Corporation, 20010 Century Boulevard, Germantown, MD 20767. Price: $9.75 to subscribers to Topics in Health Care Financing (subscription rate: $29.75 per year - four issues). This document is not available to non-subscribers.

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THIRD PARTY PAYMENTS

Alternative Funding Sources for Drug Abuse Treatment Programs

TRAINEE'S HANDBOOK

by

Ira Priesman

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CG013843

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PREFACE

This course is designed to introduce you to "third party payments" by explaining the nature of the third party reimbursement system, identifying third party payers, discussing requirements for obtaining third party reimbursements, and considering the implications for program operations.

This manual is not a cookbook, nor is the course a roadmap by which you automatically achieve your objectives by rigidly following a set of directions. The course material will tell you what must be done in attempting to obtain third party payments, but success cannot be guaranteed. What the course will do is alert you to what is involved in attempting to secure third party payments and assist you in planning for them. You should be aware that many factors beyond your control and the purview of the course will affect results. Among these are client characteristics, state regulations, receptivity of insurance companies, local attitudes, and client reactions.

This manual serves as a basic text for the course and subsequently as a resource and reference handbook. Suggested procedures, sample forms and other materials are included. These are examples only and may not be suited to your needs; they may be used as they are, modified, or disregarded, as you see fit.

Financing health care services is not a static process; therefore, some of the information presented may soon be outdated. The information contained here, and that presented during the course, should be used in light of its limitations.

Many people, both within and outside of the National Drug Abuse Center, contributed to the development of this course. Specific thanks, however, must be given to Ann Bauman, Thomas Cantwell, and Charles Galle for their assistance in preparing portions of the Trainee Handbook. Words of thanks must also go to the members of the External Review Panel for Third Party Payments: Fred Bennik, Senior Instructional Technologist, System Development Corporation; Dr. Robert Filep, Professor of Communications and Instructional Technology, University of Southern California; Steven Karten, Deputy Assistant Commissioner for Addiction Programs, New York City Department of Health; Carl Thistel, Administrative Coordinator, Shepard-Pratt Hospital, Towson, Maryland; and Nancy Wynstra, formerly with the Drug Abuse Council, Washington, D.C. Particular thanks are given to Ms. Mary Cahill, Program Analyst, OPDA NIDA, for her assistance in ensuring the technical accuracy of the material presented. Virginia Burchett is thanked for her cover design and graphic work. Finally, accolades must be accorded to Patti Lowery's editorial staff,

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particularly to Normandie Kamar, whose untiring work made the manuscript possible.

The National Drug Abuse Center welcomes feedback from those who have taken this course and/or used this manual. Comments on the usefulness of this material are especially welcome. We are also interested to know whether any topics may have been treated too briefly or omitted altogether. Reactions to the clarity and organization of the manual will help in making revisions. Communications should be addressed to National Drug Abuse Center, 1901 North Moore Street, Arlington, Virginia 22209.

Ira Priesman
Course Manager

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SECTION 1

BACKGROUND & INTRODUCTION

At the same time that health care costs are rising, federal funding is becoming more constrained. Many types of providers in the health care delivery system are therefore devoting increased attention to developing sources of support that will assure continued adequate funding for their programs.

Private health insurance has assisted individuals in meeting the costs of many traditional types of health care. The advent of such programs as Medicare, Medicaid, and more recently title XX (social services funding), has made public financing an increasingly more important source of funding for health and social service programs. Currently, considerable attention is being given to the development of some form of national health insurance as a means of providing health care benefits to most of the people in this country.

Thus, at the present time, and for the foreseeable future, these and other sources of "third-party" funding will constitute an essential element in the system of financing health care in the United States.

WHAT ARE THIRD PARTY PAYMENTS?

Medical treatment normally involves two parties: a patient (or client) who receives some type of treatment or service and an individual or organization that provides that treatment or service.

The provider may be a physician, counselor, hospital, clinic, residential treatment center, or some other source. The provider may be reimbursed directly by the client or indirectly by an insurance company (private third party) or public agency (public third party). The last two are referred to as "third parties" because they are not directly involved in the service encounter. For purposes of this course, then, "third party payments" is defined as: payment for service provided to an individual by one who is neither the receiver nor provider of the service.

HOW THIRD PARTY REIMBURSEMENT WORKS

The basic characteristic of third party payments is that services are paid for (either in full or in part) by someone (or some entity) who is neither the individual receiving the service nor the person or organization providing the service.

There are two basic ways in which a provider is reimbursed by the third party. In the first, the provider renders service or treatment to a client who is eligible* to receive payment for services from a third party payer. The provider sends bills for the service, together with any necessary claim forms, to the third party payer. The payer then reviews the claim, and if it is in order, payment is made directly to the provider. This method is sometimes called the assignment method, as the client must formally assign his right to the payment for the claim to the provider. This method is typical of Medicare, Medicaid, and Blue Cross/Blue Shield (see Figure 1.1). In the second method, the provider sends a bill to an eligible client who pays it and then submits a claim to the third party. If the claim is approved, the third party then reimburses the client (see Figure 1.2).

Whichever method is used, some type of claim form must be submitted along with the bill for services. The claim form provides the third party with information needed to determine whether the claim should be paid. This determination is generally based on three factors: eligibility of the client, eligibility of the provider, and eligibility of the service rendered. The specific criteria on which these eligibility determinations are made are noted in the insurance policy (in the case of private payers) or in federal and state regulations (in the case of public third party payers).

Client Eligibility

Client eligibility refers to the determination of whether the individual receiving services is entitled to benefits from a third party. In the case of private third parties, an eligible client is one who has either purchased an insurance policy for himself and/or his family (individual policy) or has had it purchased for him by his employer, union, fraternal organization or other source (group policy). In the case of public third party payers, an eligible client is generally one who is entitled to benefits provided by one of the programs established through the Social Security Act (i.e., Medicaid, Medicare, title XX). Individual eligibility in the case of public payers is generally related to low income and either physical condition (e.g., age, blindness, inability to work) or welfare status (e.g., AFDC recipients).

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*An "eligible" client is one who meets the client criteria established by the payer and has formally established a relationship with that payer.

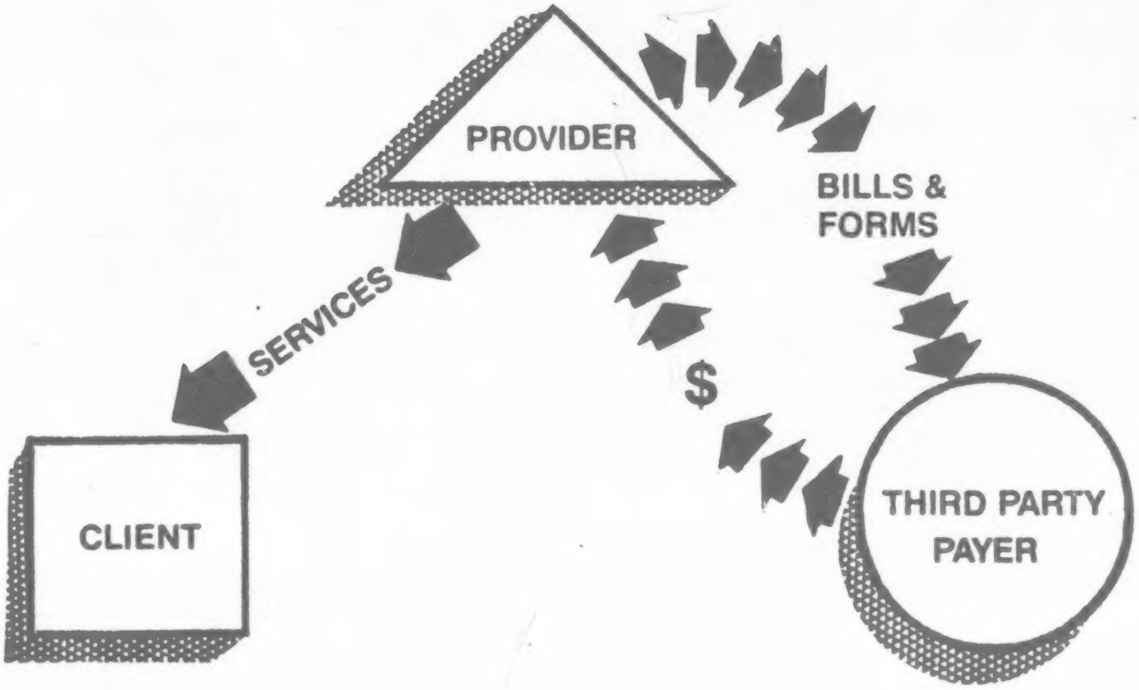
PROVIDER
BILLS & FORMS
SERVICES
$
CLIENT
THIRD PARTY PAYER

FIGURE 1.1. Direct Reimbursement of Service Provider

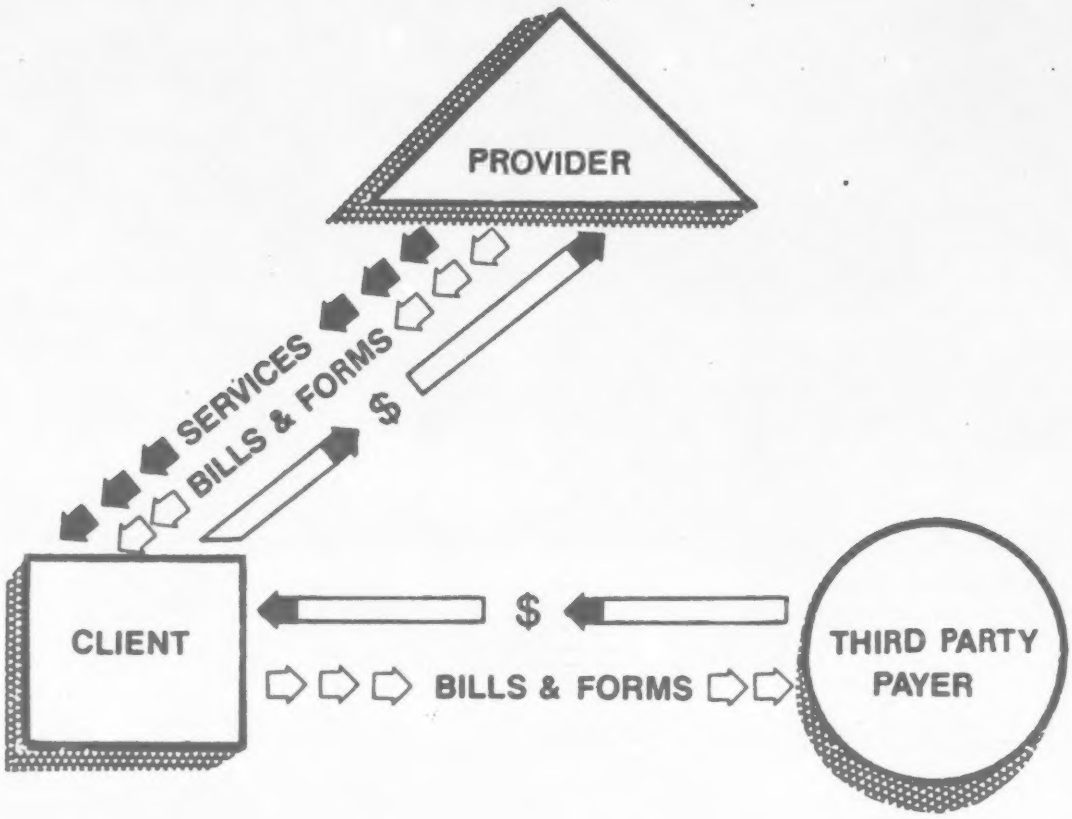
PROVIDER
SERVICES
BILLS & FORMS
$
CLIENT
$
BILLS & FORMS
THIRD PARTY PAYER

FIGURE 1.2. Indirect Reimbursement of Service Provider

Provider Eligibility

Provider eligibility refers to the determination of whether the individual or institution providing services is entitled to be reimbursed, directly or indirectly, by a given third party. Provider eligibility criteria generally relate to the capability of the provider to render quality service. This may be determined directly by the payer (e.g., through an on-site inspection) or indirectly as a result of the provider's having met standards set up by the state or by a credentialing organization such as the Joint Commission on Accreditation of Hospitals (JCAH).

Service Eligibility

Service eligibility refers to a determination of whether the third party will pay for the specific treatment or service rendered to an eligible client by an eligible provider. Generally, third parties will not pay for all services provided to clients and there is considerable variability among providers with respect to the particular services that are covered. The specific services covered are generally designated in the insurance policy (private payers) or in the legislation and/or regulations governing the program (public payers).

Service eligibility is predicated on an acceptable "condition of admission." That is, the payer must accept the illness or disability being treated as an eligible basis for the benefits provided. If, for example, the payer does not specify drug addiction as an acceptable condition for payment of benefits, no reimbursement would be available.

WHO ARE THE PAYERS?

There are many kinds of third party payers. The most commonly known are profit-seeking insurance companies (e.g., Aetna, John Hancock, Prudential, etc.) and Blue Cross/Blue Shield, a nonprofit association of medical insurers. Currently, however, the public sector has come to play a significant third party role. For several groups (welfare recipients and other low-income people, the aged, disabled, Social Security beneficiaries, and dependents of military personnel) the federal/state governments serve as the primary third party through programs such as Medicaid, Medicare, and title XX.

There are also specific agencies that might not be thought of as third party payers. The departments of welfare and vocational rehabilitation, for example, can pay for various types of supportive and nonmedical services to low income individuals who might not otherwise be covered by third party payers.

At present, most clients of drug abuse treatment programs, due to economic status, are more likely to be covered by public third parties than by private third party payers.

WHAT IS THE THIRD PARTY PAYMENTS SYSTEM?

The three parties in a third party payments system are clients (or service recipients), service providers, and payers. The likelihood of a given provider's being reimbursed by a particular payer for services to a specific client is related to the three factors of client, provider, and service eligibility. That is, there must be a match between the specific payer's client, provider, and service eligibility requirements and the characteristics of the particular client, provider, and service involved. The specific criteria established for each of these factors is determined by federal and state regulations (in the case of public third parties) and individual company requirements (in the case of private third parties). In the case of public third party payers, federal regulations generally establish certain minimum criteria of client, provider, and service eligibility for each payment program. However, state regulations vary considerably, so that the same payment program may have different eligibility criteria in different states.

It is not possible to give either simple or general directions for obtaining third party payments. Rather, *a determination of the feasibility of obtaining such reimbursement, and the specific procedures to be used in doing so, must be worked out by each service provider. This can be accomplished by determining the various eligibility criteria that must be met for each payer and relating these to the characteristics of your client population, your program, and the type of services offered.* This type of analysis will permit you to assess the likelihood of obtaining third party reimbursements in general and to identify the payers with whom you will stand the greatest chance for success. The specific facts needed for this assessment are given in this manual.

WHY COLLECT THIRD PARTY PAYMENTS?

Third party payments offer several potential benefits to a drug treatment program. These benefits include:

- Source for required "match" funds
- Reduction of dependency on a single funding source
- Expansion and/or improvement of the program
- Preparation for national health insurance
- Improved program credibility

Let us examine some of these benefits in greater detail.

Source for Required "Match" Funds

Historically drug abuse programs have relied heavily on federal "categorical" funding support combined with local matching funds. However, rising health care costs, coupled with funding constraints at all levels of government, have created a real concern.

Alternative sources of funding may need to be identified if local funds are not available. Third party payments may help to alleviate some of the financial burden.

It is important to note that at the federal level there is continued support for services provided under legislative authorities such as Medicaid and Medicare. These are sometimes referred to as "uncontrollable" budget items, as opposed to "controllable" budget items such as categorical program funding. In periods of reduced budgets, the "controllable" budgets are, of course, the more vulnerable. Thus, it is important for drug abuse treatment programs insofar as possible to become incorporated into the system that is more likely to receive continued federal funding support.

Reducing Dependency on a Single Funding Source

Increased reliance on third party payments frees a program from dependence upon any one organization, individual, or political climate; third party payers include many government programs and hundreds of individual insurance companies.

Third party payment also creates a more predictable financial situation. Consider a treatment facility with an annual operating budget of $500,000. Let us assume $250,000 comes from third party reimbursement, with the other $250,000 being a combination of a $150,000 federal grant and $100,000 in local donations. The third party reimbursements may consist of payments from such sources as Medicaid, public social service funds, and/or various private insurers. The particular combination of payers will depend upon the nature of the program's client population. It is unlikely that any single event, short of a national catastrophe, would have a significant effect on funding for the subsequent year with respect to the $250,000 received from third parties and the $100,000 local share. Thus, even in the event of a complete withdrawal of federal support, the program could continue to operate, though at a reduced capacity. On the other hand, let us consider a facility that has a $500,000 annual operating budget, but depends upon a $400,000 grant with $100,000 in donations. It wouldn't take much of a cutback in funding by the granting agency to have a marked impact on the $400,000 budget of that operation. Dependency on funding is less troublesome when spread over a broad base, and, in general, the third party mechanism does just that.

Expanding or Improving the Program

To the extent that third party revenues represent additional funds, they have potential for creating more treatment slots, improving the quality of services offered, or expanding the types of services provided.

Federal requirements regarding accountability for, and use of, third party revenues are set forth in Chapter 1-420 of the Public Health Service (PHS) Supplementations to the Department of Health, Education and Welfare Grants Administration Manual, a portion of which is quoted below:

> GRANT RELATED INCOME
>
> The grantee is accountable to the Government for grant-related income generated by activities performed under PHS grants. Some examples of grant-related income are: proceeds produced by the sale of products or services, such as laboratory tests or computer time; payments received from patients or third-parties for medical or hospital services; and fees for personal services performed in connection with and during the period of the grant-supported activity.

> Records of the receipt and disposition of grant-related income must be maintained by the grantee in the same manner as required for the grant funds which gave rise to the income.
>
> Disposition
>
> Except for the special circumstances listed in the paragraph below, all grant-related income shall be treated in accordance with one or a combination of the following options, to be designated in the grant's terms and conditions:
>
> 1. Used by the grantee for any purposes that further the objectives of legislation under which the grant was made;
>
> 2. Deducted from the total project costs for the purpose of determining the net costs on which the Federal share of costs will be based.
>
> If the terms and conditions of the grant do not specify disposition, the grantee shall select one or a combination of the above options.
>
> (NOTE: Remainder of Chapter 1-420 has been omitted)

Thus, unless the terms and conditions of your grant specify what disposition is to be made of third party revenues, you may select which of the two options will be exercised.*

Preparing for National Health Insurance

It appears likely that there will be some form of national health insurance; what is uncertain is when it will come and what form it will take. It is important for drug abuse programs to develop the capacity to utilize national health insurance as soon as it becomes available. Planning for other types of third party payments will facilitate tying into a national health insurance system.

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*However, state policy or administrative procedures may require that third party income, client fee revenue, etc., be returned to the state treasury or used as an offset to state funding.

Improving Program Credibility

Third party payers consider the quality of care furnished as a significant factor in determining whether they will reimburse beneficiaries for care obtained from a given provider of health services. Thus, third party acceptance of a drug program as an "eligible provider" signifies that the program has met some standard of quality imposed by an "outside" source. The standards of many such payers are quite high and, therefore, provide some validation of the program.

SECTION 2

FINANCIAL PLANNING: THE HEALTH SERVICES FUNDING REGULATIONS

Use of the third party payment mechanism creates the need for careful financial planning and management. Good financial planning and management in turn increase the likelihood of obtaining third party payments.

Some type of financial planning had to take place before federal support for your program could be obtained. That is, you had to develop a budget in which you estimated cost of operation during the forthcoming funding year. If you accurately estimated the operating costs, and the federal treasury was not too lean, chances are you got the amount of money you needed. If, on the other hand, you miscalculated expenses, or your grant was smaller than you requested, at some point during the year you had to spend considerable energy and imagination trying to figure out how to shave expenses and still maintain the level of service you planned.

The above procedure is fine so long as federal funds can be relied on for the necessary (or near necessary) level of support. However, in the event that the level of federal support is significantly reduced, you will have to close up shop, reduce services, or find other funds. Finding additional sources of funds gets us to the next level of financial planning--balancing anticipated financial support from a variety of sources with anticipated costs of operation. Relying on more than one source for income requires that you determine what proportion of your projected operating costs can be derived from each source. Among these sources, third party payers must be given serious consideration.

REGULATIONS AND GUIDELINES FOR HEALTH SERVICES FUNDING

With an awareness of the potential resources available through private and public third party funding sources, the Secretary of HEW directed certain health service delivery projects, including drug treatment projects, to work towards supplementing and broadening their financial base, through utilization of third party funds. The Health Services Funding (HSF) Regulations, effective January 1, 1974, are the statement of this policy; the regulations require that drug abuse treatment and other health service delivery projects develop the capability to recover third party reimbursements to the maximum extent possible, so that federal grant dollars will be used most productively.

The following statement of the Acting Assistant Secretary for Health, which introduced the guidelines for implementing the HSF Regulations, clearly expresses the importance of seeking third party reimbursement.

March, 1975

Message from: **The Acting Assistant Secretary for Health**
Department of Health, Education, and Welfare *

The regulations and interpretive guidelines within this publication reflect the great importance the Department of Health, Education, and Welfare places on increasing the efficiency of the Nation's Health Delivery systems. Health care costs continue to climb at alarming rates, and federal spending must be reduced in order to help curb the current inflationary spiral. In the short term, at least, this means that fewer federal dollars will be available for Public Health Service Health Services Delivery projects. Clearly, if we are to preserve the program gains already achieved, projects need to aggressively pursue support from other funding sources and insure that the services that are provided make the best use of funds without sacrificing quality of care.

These are not easy tasks. For many projects the prospects for third party or patient reimbursements are at best meager, but it is important that we seek reimbursement whenever it is possible and appropriate. As stressed in the guidelines, it is equally important that projects take a hard look at internal operations. This should be a continuous process that involves objective assessment of the reasonableness of the costs of the services provided and actively strives to make the best use of the resources available. The quality of operations is a significant factor in the general acceptance of projects by third party payors and may well influence the nature of project participation in some form of national health insurance.

The Public Health Service regional and headquarters personnel stand ready to assist grantees within the limits of available resources. You should seek this help if you need it. However, outside assistance can only do so much. The ultimate responsibility for complying with these regulations must continue to rest with the grantee.

Theodore Cooper

Theodore Cooper, M.D.

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*Published in Regulations and Guidelines for Health Services Funding. Washington, D.C: Department of HEW, March 1975.

Applicability

The Health Services Funding (HSF) Regulations apply to projects dealing with narcotic addiction, drug abuse, and drug dependence, which are funded under the following authorities:

1. Section 251 of the Community Mental Health Centers (CMHC) Act (42 U.S.C. 2688 k), "Grants for treatment facilities"
2. Section 252 CMHC Act (42 U.S.C. 2688 1), "Grants... for developing specialized training programs, training personnel...and programs of special significance"
3. Section 256 CMHC Act (42 U.S.C. 2688 n-1), "Special projects for narcotic addicts and drug dependent persons"
4. Section 410 of the Drug Abuse Office and Treatment Act (21 U.S.C. 1177), "Special project grants and contracts"

All services projects supported by the National Institute on Drug Abuse are funded under one of these sections.

Requirements

The HSF Regulations require that projects submit a general plan and a financial plan reflecting planning and activity related to third party payments and direct client fees. The general plan describes how the program will attempt to obtain third party revenues and direct patient fees. The financial plan describes the management of third party revenues, and gives other fiscal information. Additionally, the HSF Regulations specify a set of project requirements to be adhered to in implementing the general and financial plans.

The General Plan

The general plan must show how the project is going to seek third party reimbursement and direct client fees. Therefore, it should identify steps already taken, or to be taken, to obtain recognition by third party payers. This should include an assessment of the program's characteristics in relation to the requirements of various third parties. If there are administrative or legislative barriers to obtaining provider status, these should be clearly specified. The plan should discuss the project's intent and actual experience with regard to billing clients directly and an analysis of the target population's ability to pay.

The general plan should include a discussion of those internal operating procedures and systems that have direct bearing on the program's financial management. These include: the statistical and cost-accounting system, intake procedures, recording of patient encounters, and billing and collection procedures.

The program's cost-accounting system is particularly important. It provides the information on which the required fee schedule is developed and it is the basis for the preparation of accurate estimates of operating costs and anticipated revenues (from grants, local share contributions, third party payments, direct client billing, etc.). Further, cost accounting must be relied upon to assist in the development of the administrative procedures required to meet the cash flow problem inherent in a third party reimbursement system.

The general plan should also include an assessment of the project's capacity, an analysis of the level at which it is operating, and the patterns of utilization of its services. If the program is underutilized, the plan should indicate how the number of clients will be increased or how the capacity of the program will be reduced.

The Financial Plan

The financial plan consists of four parts. They are: management and program objectives and planning assumptions; financial management arrangements; projections of total income; and expenditure, cost and utilization data. The first three parts require information for the immediately preceding budget period, the current budget period, and the next budget period. The fourth section requires information for just the preceding and current budget periods.

Management and Program Objectives; Planning Assumptions

The first section of the financial plan identifies planning assumptions that must be made by the project and relates these to their impact on project operations. It requires program managers to make an analysis of needs related to management and program objectives. To provide the desired services, certain employees, space, equipment and supplies are necessary. The objectives should be stated in quantifiable terms, e.g., number of clients being served in various ways. The services provided must be identified, along with realistic registration levels, estimates of third party coverage, method of obtaining necessary facilities and equipment, and approaches to recruiting and training of service and administrative staff.

Budget requirements to satisfy these objectives are then developed by computing the utilization level by type of service and identifying all costs necessary to provide the level of service. These services also may be identified as direct or supportive for later comparison with revenues actually collected.

Financial Management Arrangements

This section discusses activities the project has undertaken in order to obtain support from sources other than the Health Services Administration (HSA) or the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). These sources must be identified and contacts documented. The sources include local, state, federal (other than HSA or ADAMHA) and private agencies, as well as third party payers. The section also identifies the person in the management structure who will pursue the negotiations with third party providers and attempt to obtain other sources of revenue, as well as what percentage of time will be devoted to this function. Finally, future plans for these functions are noted here.

Projections of Total Income

This part of the financial plan includes a Public Health Service (PHS) form called Financial Plan-Summary Sheet. It asks for annualized data concerning the previous year's revenues and the projections of revenue for the current and coming years. This does not mean that you must necessarily show an increase in revenue from non-ADAMHA sources. However, if your level of dependency upon ADAMHA funds is unchanged from year to year, you should be able to state clearly why other sources of revenue are unavailable to you. Stating why other revenues are not available is the proof that attempts have been made to obtain them. The revenue data is identified as fee-for-service or as prepayment, to reflect your cash flow situation. Cash flow problems arise when services are performed in advance of payment for them, as in fee-for-services and insuror-reimbursed arrangements. The

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categories of revenue encompass every area from federal grants to foundations, endowments and other sources, including direct client and third party payments.

Note: The Financial Plan form must be completed and submitted with all grant applications. Awards to NIDA-supported programs are contingent on receipt of a Financial Plan. (Shown on next page.)

Expenditure, Cost and Utilization Data

This part includes page two of the Financial Plan--Back-Up Information. It is an array of the number of clients who are eligible to have the costs of services paid for by a third party payer, the amount of these costs that has been filled, the amount collected and the per-client amount this revenue represents. Other information is also recorded on this page: the number of clients who receive free services, the target population, the user population, the number of encounters (the number of times that services are used), total costs, and cost per client and per encounter. A statement of total operating costs, total income and a balance is also required.

To develop an acceptable financial plan, you must identify a target population that needs services and for whom you can project the level of service utilization. You must be able to develop a budget to provide those services. You must show that you have made efforts or have the ability to make efforts to capture funds from sources other than ADAMHA. Those sources should include third party payers, both public and private. You must have a means of accounting for funds received previously and funds for which you are applying. You must have procedures for determining whether clients are eligible to have a third party pay the cost of their treatment. Remember, though, that you must not refuse treatment to anyone based on their inability to pay.

Project Requirements

Section 50.105 of the HSF regulations relates to management structure and the methodology necessary to realize the general plan and the financial plan. It requires projects to develop the appropriate organizational structure, management skills, and operating procedures needed to implement the plans.

HEALTH SERVICES FUNDING
FINANCIAL PLAN—SUMMARY SHEET

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Public Health Service

PROJECT IDENT. NO.(S)
(Grant or Contract)

NAME OF INSTITUTION

PROJECT TITLE

	ACTUAL			ESTIMATED			ESTIMATED		
	PREVIOUS BUDGET PERIOD (YEAR)			THIS BUDGET PERIOD (YEAR)			NEXT BUDGET PERIOD (YEAR)		
	PREPAYMENT	FEE-FOR-SERVICE	TOTAL	PREPAYMENT	FEE-FOR-SERVICE	TOTAL	PREPAYMENT	FEE-FOR-SERVICE	TOTAL
I. INCOME									
A. FEDERAL SUPPORT-THIS GRANT/CONTRACT									
B. STATE AND LOCAL GOVT.									
1. STATE									
2. LOCAL									
C. THIRD PARTY PAYORS									
1. MEDICARE									
2. MEDICAID									
3. OTHER *(Specify)*									
a.									
b.									
c.									
d.									
e.									
4. TOTAL - SECTION C									
D. DIRECT USER PAYMENTS									
E. TOTAL PAYMENTS FOR SERVICES *(C4 + D)*									
F. FOUNDATIONS, ENDOWMENTS, AND OTHER PRIVATE SOURCES									
G. LOANS									
H. OTHER *(Specify)*									
1.									
2.									
3.									
4.									
5.									
I. TOTAL INCOME (A thru H)									
II. EXPENDITURES									
III. BALANCE *(Difference between I & II)*									
A. NET									
B. CUMULATIVE									

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Appendix A (26)

PHS-5181 (FORMERLY HSM-735) (PAGE 1)
(REV. 1-75)

FORM APPROVED:
O.M.B. 68-R 1341

HEALTH SERVICES FUNDING
FINANCIAL PLAN – (BACK-UP INFORMATION)

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

PROJECT IDENT. NO(S)
(Grant or Contract Nos.)

	ACTUAL—PREVIOUS BUDGET PERIOD					ESTIMATED THIS BUDGET PERIOD		
	BILLED OR TO BE BILLED		AVERAGE PER USER	COLLECTED		TO BE BILLED		AVERAGE PER USER
	NUMBER	AMOUNT		NUMBER	AMOUNT	NUMBER	AMOUNT	
I. THIRD PARTY FEE-FOR-SERVICE INCOME	1	2	3	4	5	6	7	8
A. MEDICARE								
B. MEDICAID								
C. OTHER *(Specify)*								
1.								
1.								
2.								
4.								
5.								
TOTAL—PART I								
II. DIRECT USER PAYMENTS								
A. FULL FEE PAYMENT								
B. PARTIAL FEE PAYMENT								
TOTAL - PART II								

	ACTUAL—PREVIOUS BUDGET PERIOD				ESTIMATED THIS BUDGET PERIOD			
III. PREPAID CAPITATION INCOME *(By Source):*	NO. OF USERS	NO. OF ENROLLEES	INCOME	AV. PREMIUM AMOUNT	NO. OF USERS	NO. OF ENROLLEES	INCOME	AV. PREMIUM AMOUNT
A.								
B.								
C.								
D.								
E.								
F.								
TOTAL - PART III								
IV. NON-PAYING USERS *(Not included in Parts I, II, or III above)*								

V. OTHER INFORMATION	PREVIOUS BUDGET PERIOD	THIS BUDGET PERIOD	FOOTNOTES
A. TARGET POPULATION			
B. USER POPULATION			
C. TOTAL NUMBER OF ENCOUNTERS			
D. TOTAL OPERATING COST			
E. TOTAL INCOME			
F. COST PER USER (D ÷ B)			
G. COST PER ENCOUNTER (D ÷ C)			

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Specific recommendations are that a project have:

1. A governing body that has full legal authority and responsibility for overall conduct of the project
2. A chief executive officer who has been delegated the authority for administration of the project
3. Sufficient qualified personnel to carry out the financial and administrative requirements of the project
4. An organization chart, job descriptions, and function statements that delineate relationships among the major staff functions and among the staff, grantees, advisory board, etc.
5. Financial data and reports that accurately identify costs and use standard definitions and generally accepted accounting practices
6. Current personnel and administrative policies and procedures
7. Registration and other direct data systems that identify third party eligibility, ability to pay, and actual services rendered
8. Billing and collection policies and procedures
9. Assessment procedures to measure direct service personnel's productivity and levels of service utilization

Section 50.105 requires that policies be instituted to determine the ability of clients to pay for services. Clients must be charged in accordance with this determination. However, the section stipulates that charges shall not be a barrier to services.

This section requires programs to bill for those services that are covered by legal obligation of a third party, including the federal government. This is an "every reasonable effort" requirement to become familiar with potential third party payers and their requirements. It is recommended that contacts be made with Single State Agencies, state Medicaid and/or title XX authorities, and relevant private third party payers to obtain state-specific information.

Additionally, you are required to have operative procedures for determining which clients are eligible to have their treatment paid for by a third party. If a significant part of the cost of your program is to be reimbursed by a third party payer, you must have a written agreement with that payer. If your program has tried and failed to obtain such an agreement, these efforts must be documented.

Maximum Coordination of Activities with Other Health Services

The regulations require projects to coordinate their efforts with other agencies serving the target population to preclude an overlap of services. This requirement presumes referral activity in areas such as vocational rehabilitation, legal services, etc.

SECTION 3

KEY ISSUES

There are three basic issues that must be addressed in establishing a third party payments system:

- Eligibility of the individual receiving services (client eligibility)
- Eligibility of the individual or institution providing the services (provider eligibility)
- Elibibility of the services provided (service eligibility)

These factors are key issues because the requirements of each must be met in order to secure third party reimbursement. This section discusses these three types of eligibility.

CLIENT ELIGIBILITY

Client eligibility is the entitlement of a client to have all or part of the costs of the services he receives from a program reimbursed by a third party. To be eligible for such reimbursement, the individual must either have some form of private medical insurance or meet the criteria established by federal and state agencies for publicly financed medical or social services. Client eligibility criteria for publicly financed programs generally relate to age, physical condition, or economic status. (These are discussed in some detail in Section 4.)

Determining Client Eligibility

Determining whether a client has, or is eligible for third party payments is basically an information-gathering and review function. Information on which to make such a determination must be obtained from each client. It is recommended that this function be performed at the time of intake so that the required data are collected along with other client information. This data must then be reviewed to establish the client's eligibility for third party reimbursement.

Determination of client eligibility for third party reimbursement should be the responsibility of at least one staff member, preferably an intake counselor or member of the administrative staff. This individual, who may be referred to as the Third Party Payment (TPP) Specialist, should become intimately familiar with the client eligibility criteria of those third party payers deemed to be relevant to the program, as well as with the forms and procedures required for obtaining benefits from these payers. After locating each state agency that is responsible for a third party payment program, the TPP Specialist should also identify one or two knowledgeable individuals in each agency, and establish a working relationship with them. Such contacts will be extremely helpful in obtaining answers to technical questions about the payment program, and certifying and obtaining benefits for eligible clients.

Determining a client's eligibility for third party coverage will require the TPP Specialist to: 1) determine if the client has private medical insurance; 2) determine if the client has coverage provided by a public third party; or 3) determine if the client is eligible for coverage by a public third party payer. The last determination is accomplished by relating the client characteristics data recorded on the intake form to the client eligibility criteria of the various public third party payers. Where a potential reimbursement source is identified in this way, the client should be assisted in applying for assistance from the relevant agency.

Information Needed to Determine Client Eligibility

The first thing to be determined is whether or not the client has third party coverage. There are several factors that should be investigated to help determine this. The following possibilities should be explored for both incoming and enrolled clients:

- The client may have private individual insurance (e.g., Blue Cross/Blue Shield, Travellers, Aetna).
- The client may be covered under a policy held by a parent or spouse.
- If the client is employed, he may be covered by a group policy.
- If employment has recently been terminated, the client's group policy may have a conversion privilege to an individual policy.
- The client may be entitled to, or receiving benefits or services from, a public assistance program such as Aid to Families with Dependent

Children, Supplemental Security Income, Medicaid, Medicare, title XX, etc., and thus be entitled to benefits that will cover some of the services to be provided.

- The client may be enrolled in a Health Maintenance Organization (HMO) that has contracted with the treatment program to provide services to addicts.

In assessing eligibility for private insurance, it may be necessary to assist the client in determining if any coverage possibilities apply. Here are some suggestions:

- Ask the client to look through his or her wallet, purse, stash bag or whatever, to see if there is an insurance identification card.
- Ask if a parent or spouse has insurance.
- Let the client call a spouse/parent/co-worker to check on whether there is some insurance coverage.
- If the client is employed or has been employed recently, ask if he remembers whether the company provides health insurance.
- Suggest that the client call the employer to find out about coverage from the personnel office.
- Determine if the client has some type of insurance coverage brochure prepared by his employer or is aware of anything like it. You may want to show the client an example of such a booklet.

Note: The following actions require prior written permission from the client. See Section 5 for discussion of confidentiality issues.

- Call the family's insurance broker or agent, if the client or some member of his family has private medical coverage.
- Call the personnel section of the client's employer to determine if he is covered by a group policy and the nature of the coverage.

If, as a result of one or more of the preceding steps, you have determined that the client has private health care insurance coverage, the next step is to determine if it covers the treatment of drug addiction. If so, you will need to know such details as: provider eligibility requirements, what services are covered, and what, if any, limitations on coverage exist (e.g., maximum length of time and/or cost, exclusion of condition if it existed prior to the writing of the policy, etc.).

It is not likely that the client will know this information. Therefore, it may be necessary to obtain such details either by examining the client's insurance policy itself, or through the aforementioned contacts with employer or insurance agent.

> *__NOTE__: If some or all of your program's services are covered under the client's policy, record this fact along with such data as name and address of underwriter, client's policy number, effective dates of policy, specific type of services covered, and any limitations on the coverage. This data should be maintained so that it is readily accessible to the individuals responsible for billing.*

If the client does not have private health care insurance, determine his eligibility for benefits provided by one of the publicly financed medical or social service programs. This will necessitate obtaining information regarding income (individual and family), employment status (individual and family), welfare status (current welfare recipient or eligible), dependency status, nature and extent of physical/mental handicaps (the latter may require that arrangements be made for formal testing), and other data relevant to state requirements. If the client appears to be eligible for this type of coverage, he should be assisted in applying for the appropriate program. The TPP Specialist may merely provide the client with information on the steps he must take to obtain coverage or actually work with him in doing this. Obviously, there is a practical limit to the actual amount of assistance you can give to any one client. However, some individuals will need more support than others in finding their way through the maze of paperwork and processes that tend to overwhelm the applicant.

If the client is not eligible for any form of third party reimbursement, a determination should be made (based on program policy) as to whether the client's income level (individual or family) warrants that he be charged for the services provided.

> *__Note__: Whatever action is taken regarding reimbursement for services (third party payments, direct client payment, or no charge), it is imperative that it be recorded and readily available to the individuals responsible for billing.*

Validation

We have seen that much information needs to be collected regarding your clients; a good bit of it goes considerably beyond that which you are currently collecting. It may appear to be not only burdensome, but an invasion of (or at least an assault on) privacy. Nonetheless, you need not only to ask for personal information, but to verify what you are told. This brings us to the need for validation.

Why Validation?

If a program relies on third party revenue to cover some of its operating costs, accurate client data is essential in order to provide the basic information that will be required by the third party payers. Inaccurate or incomplete client data will certainly complicate, and may preclude, obtaining reimbursement. In the long run, both the program and its clients suffer.

Means of Validation

Listed below are some techniques for validating personal information:

- Name: Standard identification such as a driver's license, Social Security card, draft card, birth certificate, or marriage license
- Address: Same as above as well as recently postmarked mail, phone book listing
- Date of birth: Birth certificate, driver's license, baptismal certificate
- Income: Paycheck stub, W-2 Form
- Third party insurance: Identification card; contact employer insurance representative, or welfare agency.

NOTE: Written permission must be obtained from the client prior to any inquiry.

In situations where it is not possible to formally validate information, a signed and witnessed affidavit may be accepted by the third party payer.

A Word About Confidentiality

There is a problem with confidentiality that is peculiar to substance abuse programs. Normally, a person seeking medical services shows an insurance card, and the treatment facility calls to get forms for treatment and to determine the client's eligibility. In the case of substance abuse, the very telephone call without the client's permission could be a violation of his rights of confidentiality. (See Section 5 for a more detailed discussion of confidentiality). It is also a clear violation of federal law and makes the program staff liable to severe penalties. Even if one calls and does not identify the nature of the problem, the very fact that a facility is known in the community for treating substance abuse problems could violate the confidentiality to which the client is entitled. Therefore, two specific policies are recommended at this stage.

- Do not make a telephone call without the client's written permission and his full knowledge that you are going to call and ask for details of his insurance policy. Written permission is mandated by federal regulations.
- When you make the telephone call, do not discuss the nature of the problem. Just state that the client has come to your facility for medical treatment and you would like details concerning the nature of his coverage and want to have the appropriate forms sent to you.

PROVIDER ELIGIBILITY

Another key issue in third party payments is provider eligibility. This is the acceptance by a third party of a provider as a legitimate source of services for its beneficiaries. Thus, an eligible client must receive services from an eligible provider. In nearly all cases, approval of a facility means that the service provider has met some type of formal credentialing requirements established by either the state in which it operates (e.g., licensure), a professional organization, or a recognized accrediting institution. Many third party payers do not attempt to approve or disapprove the eligibility of each individual provider.

To do so would be both impractical and beyond their level of expertise. Rather, they accept as eligible those providers who meet standards developed by recognized and acceptable outside sources. However, the specific type of accepted credentialing varies among the third parties. Some insurance companies have established their own standards for provider eligibility; these may be in addition to or in lieu of formal credentialing. Such payers will generally make their own on-site reviews of the provider's facility to determine eligibility.

Credentialing

Credentialing is a generic term that encompasses the processes of accreditation, licensure, and certification. These terms are defined by the National Commission on Accrediting as:*

> Licensure: The process by which an agency of government grants permission to persons meeting predetermined qualifications to engage in a given occupation and/or use a particular title, or grants permission to institutions to perform specified functions.
>
> Accreditation: The process by which an agency or organization evaluates and recognizes a program of study or an institution as meeting certain predetermined qualifications or standards. It shall apply only to institutions and their program of study or their services.
>
> Certification: The process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.

Further amplification of the distinction between accreditation and licensing is provided in a report prepared by University Research Corporation, which states:**

> Licensing sets forth the minimum qualifications and duties which must be complied with in order for an agency or program to legally engage in the type of activity which is the subject of licensure. Accreditation, however, requires adherence to a higher standard and is usually voluntary rather than mandatory.

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*Study Commission, Study of Accreditation of Selected Health Educational Programs, National Commission on Accrediting, 1972.

**Steinberg, Sheldon; Batista, Angel Luis; Bisconti, Ann; Gumberg, Irene. Credentialing of Drug Abuse Treatment and Rehabilitation Workers. Washington, D.C.: University Research Corp., February 1975.

Licensure

Licensing of drug abuse treatment programs is performed at the state level. As of January 1975, 29 states and Puerto Rico had established licensing requirements, and an additional 12 states were in the process of adopting such requirements. The status of licensing legislation in each state (as of January 1975) is given in Table 3.1.

Licensing generally represents the minimum requirements for provider eligibility. Thus, programs operating in states not having licensing standards may, at the present time, be ineligible for reimbursement from some third parties. In the absence of licensure, some Single State Agencies (SSAs) have established provisions for program approval by the SSA, which may be acceptable to some payers. Recognizing the importance of licensure, NIDA has strongly recommended the development of licensing procedures for drug abuse treatment programs in all states.*

The importance of licensing cannot be overemphasized. Therefore, it is recommended that where state licensure for drug abuse treatment programs does not exist, Single State Agencies initiate actions toward this goal. Provisions for licensing or accreditation might include--**

1. minimum standards for maintenance and operation of each type of drug abuse treatment and rehabilitation facility which each such facility must meet in order to qualify for licensure;
2. a description of the specific methods for licensing the facilities which qualify under the standards and identification of the persons or agencies responsible for carrying out such methods; and
3. a description of the sanctions or penalties imposed for noncompliance and the incentives, if any, offered for compliance.

Accreditation

Formal accreditation of drug abuse treatment programs does not exist at the present time. However, the Joint Commission on

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*NIDA Notice to SSAs, number 36, dated March 3, 1976.

**Federal Register, Section 546.107, August 28, 1973.

Accreditation of Hospitals (JCAH) has developed standards for the accreditation of four categories of programs: comprehensive rehabilitation, short-term detoxification, emergency, and assessment and referral.* As of June 1976, JCAH had field tested these standards and was in the process of making some revisions to them. The revisions are scheduled to be completed and the finished standards issued on or about May 1977. The initial standards, which will not be altered significantly as a result of the revisions, will remain in effect until that time.

JCAH plans to begin its accreditation process in September 1976. This accreditation will be performed in four phases:

> Phase 1, Self-Evaluation. In the self-evaluation phase, programs assess themselves using a series of checklists and questionnaires provided by JCAH. The completed forms, together with some additional documentation covering operational policies and procedures are then submitted to JCAH for review. When this review is completed, the program will receive a report indicating specific weaknesses that should be remedied before proceeding to Phase 2. Programs may take up to one year to complete this phase, the cost of which is $120.
>
> Phase 2, Policies and Procedures Review. In this phase, detailed information regarding the administrative and operational characteristics of the program is submitted to JCAH, which reviews the material and makes a preliminary assessment of the program in terms of its accreditation criteria. The cost of this phase is $600.
>
> Phase 3, On-site Review. At this time, a JCAH surveyor will conduct an on-site inspection of the facility to evaluate it in terms of the accreditation criteria established for that type of program. The cost for this phase is $310 per surveyor-day and generally requires two surveyor-days to complete.
>
> Phase 4, Accreditation. This phase constitutes JCAH's review of the on-site inspection report and final determination on the granting of accreditation. The cost of phase 4 is $400.

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*Copies of the JCAH Standards for Drug Abuse Treatment and Rehabilitation Programs may be obtained by sending $7.50 per copy to: Joint Commission on Accreditation of Hospitals, 875 N. Michigan Avenue, Chicago, Illinois 60611.

Table 3.1
Status of Licensing of Drug Abuse Programs

State	Legislation Enacted	State	Legislation Enacted
Alabama	No	Missouri	No
Alaska	No	Montana	No
Arizona	Yes	Nebraska	Yes
Arkansas	No	Nevada	No
California	Yes	New Hampshire	No
Colorado	Yes	New Jersey	Yes
Connecticut	Yes	New Mexico	No
Delaware	Yes	New York	Yes
District of Columbia	No	North Carolina	No
Florida	Yes	North Dakota	No
Georgia	Yes	Ohio	Yes
Hawaii	No	Oklahoma	Yes
Idaho	No	Oregon	No
Illinois	Yes	Pennsylvania	No
Indiana	Yes	Rhode Island	Yes
Iowa	Yes	South Carolina	Yes
Kansas	No	South Dakota	Yes
Kentucky	Yes	Tennessee	No
Louisiana	No	Texas	No
Maine	Yes	Utah	Yes
Maryland	Yes	Vermont	Yes
Massachusetts	Yes	Virginia	Yes
Michigan	Yes	Washington	Yes
Minnesota	Yes	West Virginia	Yes
Mississippi	No	Wisconsin	No
		Wyoming	No

Source: Credentialing of Drug Abuse Treatment and Rehabilitation Workers, University Research Corporation, Contract No. ADM-45-74-158, NIDA, February 1975.

The total cost for accreditation of an average program will be approximately $1,750; however, a program may stop the accreditation process at any phase.

Summary: Provider Eligibility

Having accreditation and licensure indicates that a program meets certain operational and physical criteria. But these two processes also often require that staff members meet certain credentialing requirements. Generally, either key staff members and/or a given proportion of the total staff must be licensed or certified before a program can be credentialed, particularly in the case of accreditation.

What this means to you is quite simple: YOUR PROGRAM AND PROBABLY SOME OF YOUR STAFF SHOULD BE CREDENTIALED IN ORDER TO MAXIMIZE THIRD PARTY REVENUES.

Because there is a precedent for reimbursing physicians' services and services provided under a physician's supervision, reimbursement may be easier to obtain if the program employs licensed physicians.

However, certification and the formal credentialing of other staff is also important and will continue to grow in importance. Therefore, in many cases, success in garnering third party payments will be related to a program's effectiveness in upgrading the technical capabilities of, and in subsequently credentialing, its staff.

Remember, the essence of provider eligibility is to prove program legitimacy and quality of care to the third parties. This type of proof generally means credentialing of the program and its staff.

SERVICE ELIGIBILITY

The final key issue in obtaining third party payments, service eligibility, refers to the types of treatment and services for which a third party will pay, if provided by an eligible provider to an eligible client.

The specific services covered by a third party are spelled out in the insurance policy (if a private payer) or in the federal/state rules and regulations governing the payment program (if a public third party). Since wide variations in services covered exist from payer to payer, it is important to identify the requirements

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of each payer with whom you might be dealing and relate them to the services provided by your program. In this regard, note that although the services covered by a public payer will be uniform for a given state or jurisdictional area, those covered by private payers will vary according to the type of policy held by a client. Thus, in the latter case, it will be necessary to examine the client's insurance policy to determine exactly what services are covered, noting those that correspond with services offered by your program. This information then needs to be recorded for subsequent use by the billing staff.

SUMMARY: DETERMINATION OF ELIGIBILITY

This section has discussed the basic issues of client, provider, and service eligibility. The following section will examine potential third party payers noting the specific client, provider, and service eligibility criteria of each. Additionally, programs must obtain state-specific and/or company-specific client, provider, and service eligibility criteria, and by comparing these criteria with their own program, service, and client characteristics, determine which third parties are the most relevant to them. Once this has been accomplished, contact should be made with those payers from whom reimbursements will be sought, to initiate their authorization of your program as a provider. The general procedures for obtaining such authorization are examined in the following section; however, specific procedures vary among providers.

THIRD PARTY PAYERS

This section discusses those third party payment systems that are most relevant to drug abuse treatment programs. This does not mean that any given program can expect to obtain reimbursement from all or even a majority of them. Various factors must be considered such as differing provider/client eligibility requirements, the nature of services covered, specific state regulations, etc. However, the systems discussed here represent the most likely sources for reimbursement. Each system is explained and its service, client, and provider eligibility criteria examined. By relating this information to the characteristics of your particular program you will be able to identify which third party payment systems will be most appropriate to your needs. Subsequent efforts can then be expended to obtain further details regarding specific client/provider/service eligibility requirements of those individual payers who are the most likely potential reimbursers for your program; you can then effect whatever program modifications may be required to meet their eligibility criteria.

The following discussion is divided between public and private third party payers. The major distinctions between these two groups relate to their financing mechanism, client eligibility requirements* and operational basis.**

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* Public eligibility criteria generally limit services to individuals who are economically disadvantaged, physically disabled, or aged, often at no cost to the beneficiaries, while private payers provide coverage on a fee basis only.

** Federal and state regulations versus independent company policies.

PUBLIC THIRD PARTY PAYERS

MEDICAID

Medicaid (officially known as title XIX of the Social Security Act -- Grants to States for Medical Assistance Programs) was established in 1965 as part of the federal-state public assistance system. It is currently in operation in 50 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

The original purpose of the program was to encourage the states to develop unified medical assistance programs for recipients of federally assisted payments. Subsequent objectives were to expand the nature of medical services provided and extend coverage to other low-income individuals.

The program is supported by both federal and state funds, but administered at the state level. In order to receive federal monies, certain types of coverage are mandatory and coverage must be provided for certain categories of individuals. Beyond these stipulations, states may choose to include additional types of services and/or other categories of individuals. Thus, the nature and scope of coverage vary widely.

Federal support ranges from 50 percent to 83 percent, on the basis of a formula that compares the average per capita income of the state with that for the country as a whole. This formula permits greater federal support for those states having a higher proportion of low-income residents. The nature of federal support is what is officially termed an "open-end appropriation," as it is not limited to a specific dollar amount. The actual amount of the federal payment is directly related to the amount of money spent by the state for services to specific categories of individuals (identified below). For example, if a state receiving a 50 percent federal match should expend $1,000,000 in a given quarter for Medicaid, it would receive $500,000 from the federal treasury.

Client Eligibility

There are three categories of individuals who are eligible for Medicaid:

1. Categorically Needy

   Individuals who qualify for cash assistance under one of the following programs, whether or not they are actually receiving such assistance:

- Title IV-A of the Social Security Act -- cash aid (assistance) to Families with Dependent Children, AFDC
- Title XVI of the Social Security Act -- Supplemental Security Income (SSI) for the Aged, Blind, and Disabled
- A state program supplementing title XVI

Coverage for all individuals falling into one of the above categories is mandatory, and federal financial assistance is provided on the basis of the aforementioned formula.

2. Categorically Related Medically Needy

Individuals who meet the nonfinancial requirements of the Categorically Needy whose income and resources* exceed the maximum allowed for that category, but are insufficient to permit them to meet the costs of necessary medical services.

Coverage for this category of recipient is optional; however, if a state selects this option, federal financial assistance is provided on the same basis as for the Categorically Needy.

3. Non-Categorically Related Medically Needy

Individuals who do not meet either the financial or nonfinancial eligibility criteria established for the Categorically Needy (see above) but who are deemed by the state to lack sufficient income to pay for necessary medical services.

Since no federal monies are available for this category, states have complete freedom in defining the eligibility criteria. (As of June 1976, only five states--California, Kansas, Maryland, New York and Pennsylvania--provided this type of coverage.)

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* "Resources" refers to tangible assets owned by an individual such as stocks and bonds, life insurance, jewelry and other personal property (generally, only if in excess of a specified amount), etc. The specific items considered as resources will vary from state to state.

Table 4.1

Categories of Eligible Individuals under Medicaid, by State.

	Categorically Needy	Categorically Related Medically Needy	Non-Categorically Related Medically Needy		Categorically Needy	Categorically Related Medically Needy	Non-Categorically Related Medically Needy
Alabama	X			Montana	X	X	
Alaska	X			Nebraska	X	X	
Arizona	X	X		Nevada	X		
Arkansas	X	X		New Hampshire	X	X	
California	X	X	X	New Jersey	X		
Colorado	X			New Mexico	X		
Connecticut	X	X		New York	X	X	X
Delaware	X			North Carolina	X	X	
District of Columbia	X	X		North Dakota	X	X	
Florida	X			Ohio	X		
Georgia	X			Oklahoma	X	X	
Hawaii	X	X		Oregon	X		
Idaho	X			Pennsylvania	X	X	X
Illinois	X	X		Rhode Island	X	X	
Indiana	X			South Carolina	X		
Iowa	X			South Dakota	X	X	
Kansas	X	X	X	Tennessee	X	X	
Kentucky	X	X		Texas	X		
Louisiana	X			Utah	X	X	
Maine	X	X		Vermont	X	X	
Maryland	X	X	X	Virginia	X	X	
Massachusetts	X	X		Washington	X	X	
Michigan	X	X		West Virginia	X	X	
Minnesota	X	X		Wisconsin	X	X	
Mississippi	X			Wyoming	X		
Missouri	X						

The specific categories of individuals eligible for Medicaid in each state are shown in Table 4.1.

Additional federal requirements regarding client eligibility criteria relate to age, income, and state residency.

Age: Any individual 65 years or older, and any child under 21 who is classified as a "dependent child" under AFDC, must be covered.

Income: Income requirements are established by the state and, therefore, vary considerably.

State Residency: All residents of a state must be covered regardless of length of residency.

What this means is that, for the most part, client eligibility for Medicaid is limited to:

- AFDC recipients
- Dependent children of AFDC recipients under 21 years old
- Individuals who are 65 years of age or older
- Individuals who are blind
- Individuals who are disabled and qualify for Supplemental Security Income (SSI). In order to qualify, individuals must be unable to work for a period of one year as a result of a physical or mental condition other than drug addiction.

Services Covered

Required Services

Medicaid requires states to provide eligible clients with certain services. These are:

- Inpatient hospital services other than service in an institution for tuberculosis or mental diseases
- Outpatient hospital services
- Other laboratory and X-ray services

- Skilled nursing facility services other than services in an institution for tuberculosis or mental diseases
- Early and periodic screening, diagnosis, and treatment (EPSDT) of physical and mental defects in eligible individuals under 21
- Family planning services
- Physicians' services
- Home health care services

Optional Services

The following services may be offered at the option of the state:

- Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law, such as podiatrists and chiropractors
- Private duty nursing services
- Clinic services
- Dental services
- Physical therapy and related services
- Prescribed drugs, dentures, prosthetic devices, and eyeglasses
- Other diagnostic, screening, preventive, and rehabilitative services
- Inpatient hospital services and skilled nursing facility services, for individuals aged 65 or over, in an institution for tuberculosis or mental disease
- Other medical and remedial care recognized under state law and specified by the Secretary, such as whole blood, Christian Science practitioners' services, and care in Christian Science sanitoria, skilled nursing homes for persons under 21, emergency hospital services, and transportation

- Intermediate care facility services
- Inpatient psychiatric hospital services for individuals under 21

A summary of Medicaid services offered in each state is shown in Table 4.2. This table demonstrates the high degree of variability that exists among the states in the type of coverage provided.

Provider Eligibility

Under Medicaid, the state determines the specific requirements for both institutional providers (e.g., hospital, skilled nursing facility, intermediate care facility, clinic) and individual providers (e.g., physician, health care technician) are determined by the state. Approval by a state credentialing body is required for both institutional and individual providers. The services rendered by a provider must meet the state's definition of "medical or remedial services." Individual providers may be physicians, other practitioners licensed as medical practitioners by the state, or health care technicians (i.e., individuals who meet federally approved proficiency qualifications as opposed to educational, professional, or other formal criteria).

Specific types of requirements that institutional providers must meet relate to factors such as: 1) health, 2) humane treatment, 3) sanitation, 4) physical facilities (including type of construction, space, and accommodations per person), 5) fire and safety, 6) staffing (number and qualifications), 7) client records, and 8) administrative and fiscal arrangements.

In addition, many states require a formal contract or purchase of services agreement with a provider. In virtually all cases, a provider must obtain a vendor number to be used in submitting bills for services to the Medicaid authority.

There are two types of institutional providers that a state may approve for Medicaid that may be particularly applicable to drug abuse treatment programs. These are:

- Clinics: Defined as facilities that are not part of a hospital but organized and operated to provide medical care to outpatients

- Intermediate care facilities (ICF): Defined as an institution licensed under state law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment that a hospital or skilled nursing facility is designed to provide, but who, because of their mental or physical condition, require care and services (above the level of room and board) that can be made available to them only through institutional facilities

The states whose Medicaid programs cover clinic and ICF services are noted in Table 4.2.

Generally, drug abuse treatment programs are more likely to fall under the category of "clinics" than of an ICF. However, in 12 states, clinics are not eligible providers and in an additional 13 states, clinic services are limited to the Categorically Needy.

Once approved as a provider, a facility may be subject to the following requirements:

- Financial records are subject to periodic audit and financial reports may be required by the state Medicaid authority.
- Inpatient care (in short-stay hospitals) must be certified as medically necessary and must be periodically reevaluated during the extent of the patient's stay. This process, known as concurrent review, will eventually extend to all providers and become the responsibility of the Professional Standards Review Organizations (PSRO) in each of 203 geographic areas around the country.

Where a program does not meet the Medicaid eligibility criteria, individual providers (e.g., physicians, laboratory technicians) working in the facility may be able to collect individually from Medicaid for the services they render to clients. Where this type of arrangement is used, Medicaid reimbursement may be made:

> (A) to the employer of such physician, dentist, or practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer; or (B) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service . . . .*

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* Social Security Act, paragraph 1902(a) (32).

(As of January 1, 1975)

Medicaid services are subject to definition (sometimes restrictive) by each State's program

● offered only to the categorically needy¹
+ offered to the categorically and medically needy¹

	Emergency Hospital Services	Prescribed Drugs	Dental Services	Eye Glasses	Prosthetic Devices	Physical Therapy and Related Services	Private Duty Nursing	Care for Patients 65 or Older in Institutions for Mental Diseases	Optometrists' Services	Podiatrists' Services	Chiropractors' Services	Care for Patients 65 or Older in Institutions for Tuberculosis	Clinic Services	Skilled Nursing Facility Care - Persons Under 21	Other Diagnostic, Screening, Preventive, or Rehabilitative Services	Intermediate Care Facility Services	Care for Patients Under 21 in Psychiatric Hospitals
Alabama	●	●		●	●				●			●		●		●	●
Alaska	●		●					●								●	●
Arizona		●	●	●					●	●							
Arkansas	●	●	●		●			●			●	●	●	●		●	●
California	+	+	+	+	+	+		+	+	+	+	+	+	+	+	+	+
Colorado	●	●			●	●		●		●				●		●	●
Connecticut		+	+	+	+	+	+	+	+	+	+		+	+	+	+	+
Delaware		●				●		●		●		●	●			●	
Dist. of Col	+	+		+	+	+		+	+	+		+	+	+	+	+	+
Florida	●	●	●	●	●			●	●			●				●	
Georgia		●	●	●	●		●	●	●	●		●		●	●	●	
Guam	+	+	+	+	+	+			+				+	+			
Hawaii	+	+	+	+	+	+			+				+	+	+	–	
Idaho	●	●							●	●	●		●	●		●	
Illinois	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Indiana	●	●	●	●	●	●	●		●	●	●		●	●	●	●	
Iowa	●	●	●	●	●	●			●	●	●			●		●	
Kansas	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	
Kentucky	+	+	+		+	+		+				+	+	+		+	+
Louisiana	●	●			●			●				●	●	●	●	●	●
Maine	●	+	+	+	+	+	+	+	+	+	+	+	●	+	+	●	+
Maryland	+	+	+	+	+	+		+	+	+	+	+	+			+	
Massachusetts	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Michigan	+	+	+	+	+	+		+	●	+	+	+	+	–	+	+	+
Minnesota	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Mississippi		●	●					●	●			●		●		●	
Missouri	●	●	●	●				●	●			●					
Montana	+	+	+	+	+	+	+	+	+	+		+	+	+		+	+
Nebraska	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	
Nevada	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
New Hampshire	+	+	+	+	+	+	+		+	+	+		+	+	+	●	
New Jersey	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●	●
New Mexico	●	●	●	●	●	●	●		●	●			●	●		●	
New York	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
North Carolina		+	+	+				+	+	+	+	+	+	+	+	+	+
North Dakota	+	+	+	+	+	+	+	+	+	+	+		+	+	+	+	+
Ohio	●	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●
Oklahoma			+	+					+	+						+	+
Oregon	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Pennsylvania	+	●	●	+	●			+	+	●	+	+	+	+		+	●
Puerto Rico	+	+	+			+						+	+		+		
Rhode Island		+	+	+	+			+	+	+						●	
South Carolina	●	●	●	●	●	●		●	●	●	●	●	●	●		●	●
South Dakota	●	●	●	●	●	●			●	●	●		●	+		+	
Tennessee	+	+	+		+			●				+	+			●	
Texas	●	●		●				●	●	●		●			●	●	
Utah	+	+	+	+	+	+	+	+	+	+	+		+	+		+	+
Vermont	+	+			+			+		+			+	+		+	+
Virgin Islands		+	+	+	+								+				
Virginia	+	+		+	+	+		+	+	+		+	+	+		+	
Washington	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
West Virginia		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Wisconsin	+	+	+	●	●	+	+	+	●	+	●		+	+	●	–	+
Wyoming						●								●		●	

¹*Basic required Medicaid services:* State Medicaid programs are required by Federal law and regulations to offer the following basic medical services to persons receiving Federally supported financial assistance, i.e., the categorically needy: inpatient and outpatient hospital services; other laboratory and X-ray services; skilled nursing facility services for persons 21 or older; early and periodic screening, and diagnosis of persons under 21 to determine their physical and mental defects, and treatment of conditions found; family planning services (effective 1/1/73); and physicians' services. In addition, home health services must be provided to any eligible person who is entitled to skilled nursing facility services, and State Medicaid plans must assure transportation of recipients to and from providers of services. If Medicaid is extended to cover the medically needy, i.e., individuals who would be categorically needy except for their higher income, Medicaid must provide for them either the same basic services that are required for the categorically needy or a combination of seven services.

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Appendix B provides state-specific Medicaid data regarding client, provider, and service eligibility criteria as well as the identification of the relevant state authority. This information will assist you in determining whether Medicaid may be a potential third party source for your program. However, before making a final decision, it will be necessary for you to obtain specific details regarding eligibility determination and operating procedures from either your SSA or state Medicaid authority.

Obtaining Provider Status

Participation in the Medicaid program requires that a provider be certified by the state Medicaid authority as meeting its eligibility criteria; there must be a formal agreement between the provider and the Medicaid authority. A suggested procedure for pursuing Medicaid certification is outlined below:

1. Contact the state's Medicaid authority to obtain its requirements and application form for participation.

2. Review the requirements for participation and determine if your program meets all mandatory requirements. Note: Some requirements might be specified as "should" or "desirable" as opposed to "must." Although they are probably not mandatory, meeting these requirements increases the likelihood of certification; they should be met if possible. However, since some states are fairly lenient with respect to optional requirements, you should contact the Medicaid authority to determine their importance in your state.

3. If your program does not currently meet all the mandatory requirements, you must decide whether to make the necessary changes to meet these, or abandon Medicaid certification.

4. The next step, if you are pursuing Medicaid certification and believe that you meet the state's requirements, is to complete the application and submit it, along with any other required materials, to the Medicaid authority.

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5. The Medicaid authority will then review your application. If it is acceptable, an on-site inspection of your facility may be made to verify that it complies with state regulations.

6. If your application is rejected or your facility does not pass the on-site inspection, you will be notified; the shortcomings will be identified. You will have an opportunity to take the necessary actions and reapply. There is also an appeal mechanism if you wish to protest the rejection.

7. If your program is certified for participation, you will have to enter into a formal agreement with the state Medicaid authority. This agreement varies from state to state, but generally includes conditions relating to maximum charge for services, willingness to abide by the Medicaid regulations, and accessibility of financial and other records.

Reimbursement

States are required to set maximum limits on reimbursement for each type of service covered. Thus, a provider cannot be reimbursed more than the upper limit, but may receive less depending on the basis for reimbursement and/or the actual cost to the provider. Medicaid regulations stipulate that hospitals be reimbursed for inpatient care on the basis of "reasonable cost." Other service providers may be reimbursed according to state policies. However, federal regulations recommend that reimbursement be based on reasonable cost and stipulate that customary charges serve as the basis for determining the upper limit of payment for various types of services. Generally, the upper limits are established on the basis of "reasonable cost" or "reasonable charge."

- Reasonable cost: The actual cost of providing a service. However, the cost must be in line with costs of similar providers in the same locality for the same service.

- Reasonable charge: Generally based on "customary charges" or "prevailing charges."

Customary charge: The charge that a particular provider usually makes for a given service. If no one amount is charged to the majority (75 percent - 80 percent) of clients, the median charge is normally used.

Prevailing charge: A charge that lies within the range of charges that are most common within an area (i.e., a political or economic subdivision of a state).

Some states, however, have established a flat rate for specific services; this rate applies to all providers on a statewide basis.

TITLE XX: GRANTS TO STATES FOR SERVICES

Background

Title XX of the Social Security Act (officially known as Grants to States for Services), part of the Social Security Amendments of 1974, became effective on October 1, 1975. Title XX supersedes title VI (Services to the Aged, Blind, and Disabled) and that portion of title IV-A (Aid to Families with Dependent Children /AFDC/) dealing with services to eligible individuals.

The purpose of title XX is to establish a consolidated program for federal assistance that will encourage states to provide social and rehabilitative services to help low-income individuals and families obtain employment, achieve self-care, and attain family stability by providing services directed to the following goals:

1. To achieve or maintain economic self-support to prevent, reduce, or eliminate dependency
2. To achieve or maintain self-sufficiency, including reduction or prevention of dependency
3. To prevent or remedy neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserve, rehabilitate, or reunite families
4. To prevent or reduce inappropriate institutional care by providing for community-based care or other forms of less intensive care

5. To secure referral or admission for institutional care when other forms of care are not appropriate, or provide services to individuals in institutions.

Thus, title XX emphasizes the provision of social and rehabilitative services to eligible individuals, in contrast with the Medicaid and Medicare programs, which emphasize medical services. Title XX, in fact, specifically precludes services that are available to an individual under the state's Medicaid program.

The title XX program is administered at the federal level by the Social and Rehabilitation Service of the Department of Health, Education, and Welfare and at the state level by a Single State Agency established for that purpose. (This is the same agency that administers title IV-B [child welfare], IV-C [work incentive program], and IV-D [child support and paternity establishment]). Under title XX federal support is at the rate of 75 percent (except for family planning services, which receive a 90 percent match). Within the maximum of $2.5 billion per year, funds are allocated to the states on the basis of population. Note: This has been the ceiling for federal social services funding since 1972. Thus, title XX does not represent a source of additional funds. This is important, as many states are currently expending all or nearly all of their federal social service dollars and, as a result, are not likely to support new services.

Title XX regulations require that at least 50 percent of the federal share be used to provide services to individuals eligible for Medicaid; to those individuals receiving, or eligible to receive, cash payments under Aid to Families with Dependent Children (AFDC), Supplemental Security Income for the Aged, Blind, and Disabled (SSI), or state supplementary payments; or to individuals whose financial status is taken into account in determining assistance to these groups. Title XX represents a major change in the nature of federal assistance to states for the provision of social services. Previously, federal support was in a form referred to as "categorical assistance," as federal funds could only be used to assist specified categories of individuals (most typically the aged, blind, and disabled). Title XX, on the other hand, permits states considerable latitude in determining:

- What services will be made available. Basically, the only requirement is that each service offered be directed at one of the five program goals of title XX.

- Which people will be eligible for services. A state may offer one or more services to anyone who receives cash payments under AFDC or SSI or has an income that does not exceed 115 percent of a state's median income as adjusted for family size.

- Where and how services will be provided. Different services may be made available in different geographic areas within the state.

Public Participation

A major objective of title XX is to give states the opportunity to make their social services programs fit the needs of people in the state and local communities. To accomplish this, a major change has been made in the planning process.

Under title XX, a state's services plan will be subject to review by the state's citizens, initially and each time a new plan is prepared. To assure that citizens have an opportunity to review and comment on the services program, the state's title XX agency must develop a Comprehensive Annual Services Program Plan (CASPP) and make it public at least 90 days prior to implementation. A minimum of 45 days must be allowed for public comment. The final plan (noting any differences between it and the proposed plan and the reasons for such differences) must be published at least 45 days after publication of the proposed plan, and prior to implementation.

The CASPP must state:

- What the state hopes to achieve by providing services
- Which people are eligible to receive which services
- Which services will be provided in each geographic area
- Estimated expenditures for each service, category of recipient, and geographic area
- Information about program administration, use of public and private agencies and volunteers, and where people can apply for services

In addition, the description of the service plan must meet the following criteria:

1. Each service offered must be described as a separately identifiable service. In other words, broad categories such as "drug abuse services" would not be adequate; rather, the CASPP must specify "methadone maintenance," "residential care," "detoxification," and so on. However, it should be noted that drug abusers may be eligible to receive services under one or more of the other specified service categories (e.g., counseling).

2. Each service must be described as to the method of delivery. Services can be provided by the state in one of three ways:

   - Directly, through state-operated clinics or institutions maintained by the title XX agency

   - By contract (formal or informal non-monetary agreements) with other state and local government agencies

   - Under purchase of services agreement with independent (public and private) providers

Generally, medical and remedial care services are not covered under title XX, which supports social services. However, medical and remedial care services can be covered if they meet the following requirements.

- They must constitute an integral but subordinate part of a service described in the plan (i.e., the particular service cannot be provided without the essential medical or remedial care).

- They must not exceed 25 percent of the total reimbursement for the service of which the medical and remedial care is a part.

- They must not be available to the individual under the Medicaid program in the state.

- They must be explicitly identified in the definition of the service of which they are a part.

For room and board services to be covered under the plan, they must constitute an integral but subordinate part of the service and be limited by the following:

- They must not exceed 25 percent of the total amount for which reimbursement is made if room only, or board only, is provided.
- They must not exceed 40 percent of the total amount for which reimbursement is made if both room and board are provided.

In addition, the CASPP must specifically identify room and board as a component of the service plan.

Information regarding the CASPP and/or the review process in your state may be obtained by contacting the state title XX agency. The name and address of the title XX agency in your state is given in Appendix C.

Services Covered

The title XX regulations mandate:

- At least three services for SSI recipients
- At least one service directed at each of the five title XX program goals

Additionally, states are required to provide:*

- Family planning services for AFDC recipients
- Foster care services, if the state has an AFDC program

Other services may be included at the state's option providing they are consistent with title XX goals. Services that might be covered would include child care, counseling, staff training and employment-related services, health support services, information and referral activities, and particular combinations of services directed at "the special needs of children, the aged, the mentally retarded, the blind, the emotionally disturbed, the physically handicapped, alcoholics, and drug addicts." Thus, services for drug addicts may be specifically included in a state plan or some of the services provided by a drug abuse treatment program may be included in the type of services covered (e.g., health support or employment services). Note also that title XX permits the use of funds for staff training activities. Thus, a program may be able to recover all or part of the costs incurred for this purpose.

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* Failure to provide these services will result in a reduction in federal support for the state's AFDC program.

Because state plans vary, it is beyond the scope of this course to identify the specific services covered in each state. Therefore, you should contact your SSA or state title XX agency for the information necessary to help you determine whether or not title XX in your state is a likely source of funds for your program. However, the information in the state title XX charts in Appendix C may be helpful in making a preliminary determination.

Client Eligibility

Client eligibility for title XX services is limited to low-income individuals. To be eligible, individuals must either be categorically needy (classified as "income maintenance status") or meet an income test (classified as "income status").

Income Maintenance Status

Individuals are eligible under this classification if they meet one of the following categorical requirements:

- AFDC recipients
- Persons whose needs were considered in determining the needs of an AFDC recipient
- SSI recipients
- Recipients of state supplementary payments

Income Status

Individuals whose family's gross income is less than 115 percent (or, at state option, a lower percentage) of the median income of a family of four in the state, adjusted for size of family qualify in this category.

Within these two general categories, states have considerable freedom in setting eligibility criteria. For example:

- The upper limit for income eligibility can be set at any figure below the 115 percent level.
- Income limits can be different for different services.
- Income limits can be different for different categories of individuals.
- Eligibility for a particular service can be limited to a specific category of eligible individuals.

Individuals in the "income status" category may be charged a fee, depending on their income level.* Specifically, a fee must be charged if the family income falls between 80 percent and 115 percent of the adjusted median income for a family of four. A fee may be charged individuals whose family income is less than 80 percent of the adjusted level for a family of four. This specification is shown in Figure 4-1. Such fees may also be charged to individuals in the "income maintenance status." Where such fees are imposed, they must be "reasonable" and "income related." This means that states imposing a fee must establish some type of sliding fee schedule in order to ensure that otherwise eligible individuals are not denied services due to their inability to pay for such services. (See Table 4.3).

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* "Income" means the monthly total of all sources of income including wages, salary, self-employment income, dividends, interest, rental income, royalties, pensions, annuities, alimony, child support, unemployment compensation, workmen's compensation, public assistance or welfare payments, all Social Security payments, including railroad retirement, and veteran's pensions. It does not include money obtained through illegal activities.

Table 4.3

Median, 80 Percent, and 115 Percent Income Levels for Families of Four, by State
(Effective from October 1, 1975 to September 30, 1976)

State	Median	80% Level	115% Level
Alabama	$11,790	$ 9,432	$13,559
Alaska	17,223	13,778	19,806
Arizona	13,917	11,134	16,005
Arkansas	11,195	8,956	12,874
California	14,778	11,822	16,995
Colorado	14,178	11,342	16,305
Connecticut	15,404	12,323	17,715
Delaware	14,114	11,291	16,231
District of Columbia	13,599	10,879	15,639
Florida	13,427	10,742	15,441
Georgia	12,738	10,190	14,649
Hawaii	15,688	12,550	18,041
Idaho	12,605	10,084	14,496
Illinois	15,152	12,122	17,425
Indiana	14,004	11,203	16,105
Iowa	14,242	11,394	16,378
Kansas	13,758	11,006	15,822
Kentucky	11,430	9,144	13,145
Louisiana	11,430	9,144	13,145
Maine	11,330	9,064	13,030
Maryland	15,441	12,353	17,757
Massachusetts	14,393	11,514	16,552
Michigan	15,302	12,242	17,597
Minnesota	14,911	11,929	17,148
Mississippi	10,830	8,664	12,455
Missouri	$13,319	$10,655	$15,317
Montana	12,848	10,278	14,775
Nebraska	13,280	10,624	15,272
Nevada	14,803	11,842	17,023
New Hampshire	13,458	10,766	15,477
New Jersey	15,744	12,595	18,106
New Mexico	11,436	9,149	13,151
New York	14,264	11,411	16,404
North Carolina	12,163	9,730	13,987
North Dakota	14,746	11,797	16,958
Ohio	14,048	11,238	16,155
Oklahoma	12,095	9,676	13,909
Oregon	13,787	11,030	15,855
Pennsylvania	13,374	10,699	15,380
Rhode Island	13,208	10,566	15,189
South Carolina	11,799	9,439	13,569
South Dakota	12,701	10,161	14,606
Tennessee	11,591	9,273	13,330
Texas	12,957	10,366	14,901
Utah	12,843	10,274	14,769
Vermont	12,007	9,606	13,808
Virginia	13,784	11,027	15,852
Washington	14,035	11,228	16,140
West Virginia	11,443	9,154	13,159
Wisconsin	14,024	11,219	16,128
Wyoming	12,916	10,333	14,853

Source: Social and Rehabilitation Service

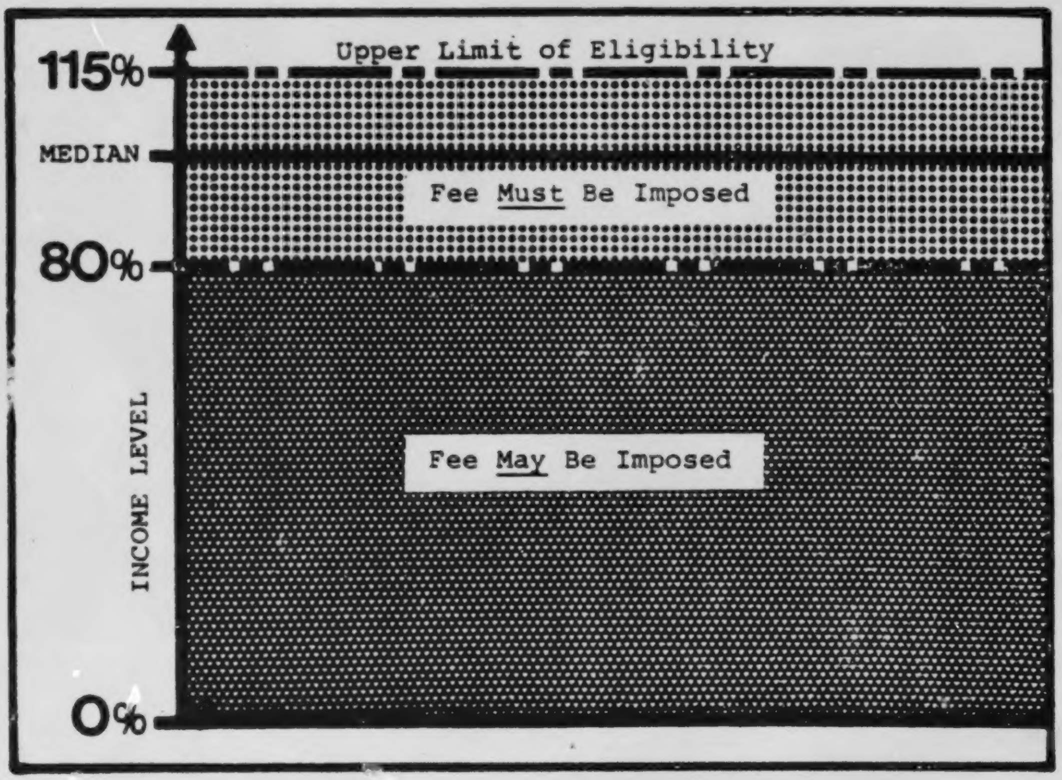

Figure 4.1 Relationship between Income Level and Fee-for-Service Requirement of title XX. (Source: National Clearinghouse for Drug Abuse Information, Report Series 35, Issue A.)

A chart for adjusting various family sizes to an equivalent income ceiling for a family of four is shown below:

Number of Family Members	Equivalent Income Ceiling (Percentage of Median for Family of 4)
1	52%
2	68%
3	84%
4	100%
5	116%
6	132%

For each additional family member, add 3 percentage points to the percentage for a family of six.

Determination of client eligibility may be made either by the state title XX agency or, at the state's option, by the provider (as a result of contractually delegated authority). Eligibility determination, whether by the state or the provider, normally cannot be made solely on the basis of statements made by the individual, except in cases where documentation is clearly unobtainable. In the latter case a sworn affidavit that has been witnessed and signed may be acceptable. Support, such as verification of income maintenance payments from the appropriate agency (income maintenance status) or paycheck stubs (income status), generally must be provided by the applicant.

Provider Eligibility

Specific requirements for provider eligibility are established by the state, and, therefore, vary considerably. Generally, requirements relate to administrative management, quality of care, delineation of services, and extent and nature of services provided.

Federal regulations require a written contract, called a *Purchase of Services Agreement (PSA)*, between the provider and the state agency. The PSA must:

- Specify a start and termination date

- Contain a detailed description of the services to be provided (including type and number of units)
- Specify the basis for, and nature of, the reimbursement procedure
- Specify the location where the services are to be performed
- Guarantee the confidentiality of client information
- Assure compliance with the Civil Rights Act of 1964
- Specify requirements for financial management (e.g., record keeping, fiscal controls, reporting and monitoring procedures)
- Provide for review of program records by state and federal officials
- Comply with other specific terms and conditions relating to the provision of services

Additionally, a program must meet the specific title XX eligibility requirements established by the welfare department of the state in which it operates.

Provider status for title XX is established with the state or local social service agency through negotiation of a Purchase of Services Agreement. *The specific terms and conditions of such an agreement and the nature of the negotiation process will vary considerably from state to state.* The specific requirements for a provider must, therefore, be obtained by contacting the title XX agency in your state. The identity of these agencies, together with some state-specific data regarding title XX plans, may be found in Appendix C.

Reimbursement

The specific procedure for receiving reimbursement from title XX will vary from state to state. However, a common procedure is for payments to be generated by individual programs, as a result of providing eligible services to eligible clients, and for reimbursement to be made by the state's title XX office to an agency (e.g., Single State Agency) that actually holds the Purchase of Service Agreement and has some type of relationship and agreement with the specific providers.

The latter agency thus functions as an intermediary between the provider and the payer. Where such an arrangement exists, the intermediary may select the basis upon which payments are allocated or distributed to the various programs providing the services. Thus, in such a case, the monies received by a provider will not necessarily be directly related to the nature and/or extent of services actually provided to eligible clients. This type of situation is diagrammed in Figure 4.2.

MEDICARE

Medicare (officially known as title XVIII of the Social Security Act -- Health Insurance for the Aged and Disabled) is a major medical insurance plan for eligible individuals who are at least 65 years old or disabled. The program is administered by the Bureau of Health Insurance (BHI) of the Social Security Administration. BHI negotiates and administers agreements with (1) service providers, (2) state agencies responsible for certifying service providers, and (3) intermediaries and carriers responsible for making payments, conducting audits, etc. Medicare is a federal program and, therefore, eligibility and coverage are uniform nationwide.

Medicare is, in fact, two separate and distinct programs. The two programs differ with respect to type of benefits, method of financing, nature of participation by beneficiaries, and the legal basis for their operation. These two programs are generally designated by sections of title XVIII from which they originate -- Part A and Part B. Part A (Hospital Insurance Benefits for the Aged and Disabled) covers hospital and post-hospital services. Part B (Supplementary Medical Insurance Benefits for the Aged and Disabled) covers physicians' services and various outpatient services. Part A is financed by compulsory contributions of employees and employers through the payroll tax, while Part B is a voluntary program financed in equal amounts from premiums paid by the insured and a contribution from general fund revenues. Part A interacts with Medicaid in that, if the recipient is eligible for Medicaid and the services are covered, Medicaid can pay for services that are not covered by Medicare.

Services Covered Part A

The services covered under Medicare Part A fall into three broad categories: inpatient hospital services, post-hospital extended care, and home health services. Several specific services are

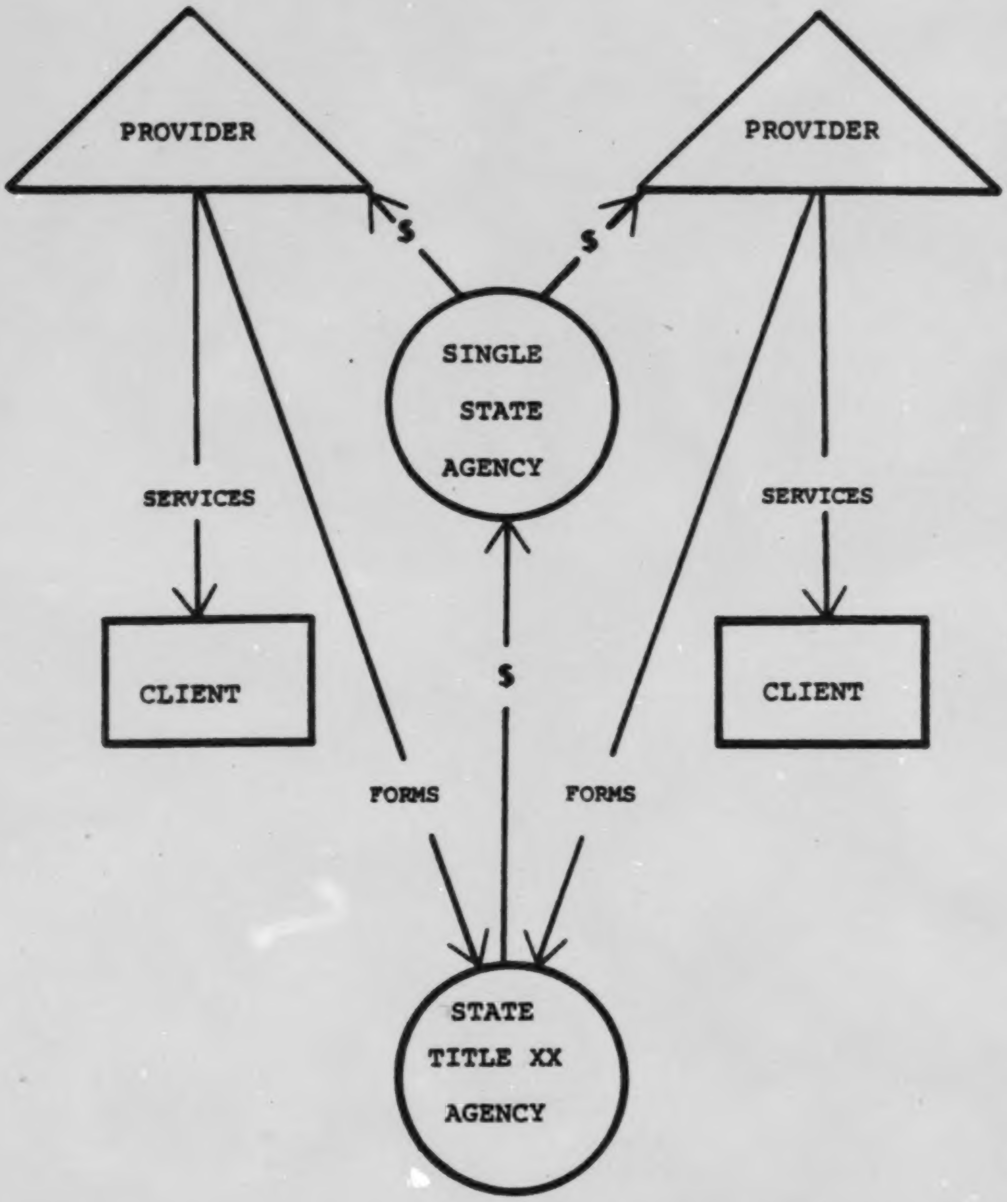
PROVIDER
PROVIDER
$
$
SINGLE STATE AGENCY
SERVICES
SERVICES
CLIENT
$
CLIENT
FORMS
FORMS
STATE TITLE XX AGENCY

Figure 4.2. Common Title XX Reimbursement Procedure

covered under each of these categories.

Inpatient Hospital Services

- Bed and board
- Nursing and related services
- Drugs, biologicals, supplies, appliances, and equipment
- Other diagnostic or therapeutic items or services ordinarily furnished to inpatients
- Services provided by interns or residents in training, if they are in an approved teaching program.

Inpatient hospital services are covered for a period of up to 90 days for each spell of illness. Also, each patient is entitled to an additional lifetime limit of 60 days of coverage for spells of illness exceeding 90 days. However, this "lifetime reserve" cannot be used for hospitalization in a psychiatric facility.

External Care Services

The following services are covered if provided by a "skilled nursing facility" to which an individual has been transferred following discharge from a hospital in which he was an inpatient for a minimum of three consecutive days:

- Bed and board
- Nursing care
- Physical, occupational, or speech therapy
- Certain medical social services
- Drugs, biologicals, supplies, appliances, and equipment
- Medical services of interns and residents in training, if they are in an approved teaching program
- Other health services generally provided by such a facility

Home Health Services

- Part-time, intermittent nursing care
- Physical, occupational, or speech therapy
- Medical social services under the direction of a physician
- Certain part-time or intermittent services of a home health aide
- Medical supplies, other than drugs and biologicals
- Medical services provided by an intern or resident in training
- Any of the above services provided on an outpatient basis at a hospital or skilled nursing facility when special equipment is required

Services Covered Part B

The services covered under Medicare Part B include, physicians' services, services and supplies related to physicians' services, outpatient services, and home health services.

Physicians' Services

The types of physicians' services covered are:

- Surgery
- Consultation
- Office visits
- Institutional visits
- Home visits

However, coverage for physicians' services rendered to individuals having a psychiatric diagnosis is limited to 50 percent of the charges unless the care is provided in a licensed general hospital.

Service and Supplies

Items covered are services of auxiliary personnel (e.g., nurses, therapists, technicians) and medical supplies (e.g., bandages, ointments, non-self-administered drugs) directly related to the services of a physician.

Outpaitent Services

This category includes diagnostic services, therapeutic services, and supplies related to such services.

Home Health Services

Part B covers the same home health services as covered by Part A; however, prior hospitalization is not required.

Client Eligibility Part A

There are three eligibility categories for Medicare Part A:

1. Individuals who have reached the age of 65 and are entitled to Social Security retirement or survivor benefits, or who qualify as railroad retirement beneficiaries

2. Individuals under 65 who have been entitled to Social Security payments because they have been disabled for 24 months (However, if the date of onset of the disability is determined to be within the past 12 months, the 24-month requirement is reduced by the number of months of prior entitlement.)

   (Individuals falling into one of the above categories receive coverage without charge.)

3. Individuals who have elected to enroll in Part B, but are not otherwise eligible for Part A, may purchase Part A coverage by paying a monthly premium.

Client Eligibility Part B

This is a voluntary program requiring the payment of a monthly premium. There are two eligibility categories:

1. Individuals eligible for Part A are automatically enrolled in (and billed for) Part B unless they decline in writing.

2. Individuals not eligible for Part A who have reached the age of 65 and are U.S. residents (either U.S. citizens or aliens lawfully admitted for permanent residence who have resided in the United States for five months preceding enrollment)

Additionally, state welfare departments may elect to "buy-in" to provide Part B coverage for eligible individuals who receive public assistance. In this case, the state pays the monthly premiums.

All Medicare beneficiaries receive an identification card. Eligibility of a particular individual for Medicare can be determined by contacting the district office of the Social Security Administration or the responsible state agency (see Table 4.4). Note, however, that such contacts are subject to the confidentiality regulations discussed in Section 5.

Provider Eligibility

Eligible providers under Part A (formally designated "providers of services") are limited to:

- Hospitals
- Skilled nursing facilities
- Home health agencies
- Clinics, rehabilitation agencies and public health agencies (for outpatient physical therapy or speech pathology services only)

Eligible providers under Part B (formally designated "suppliers of services") are:

- Physicians
- Suppliers of medical and other health services
- Suppliers of drugs and biologicals
- Independent laboratories

Eligibility for participation in the Medicare program requires that the "providers" and "suppliers" (other than physicians) comply with the statutory requirements of title XVIII and with requirements established by HEW (relating to the health and safety of patients).*

Certification that a provider (or supplier) complies with the conditions of participation (or coverage) is made by the state agency responsible for Medicare, generally on the basis of an on-site inspection. Once certification has been obtained, a provider must enter into a formal agreement with HEW. A copy of this agreement is shown in Figure 4.3.

Physicians need not meet conditions of participation nor must they contract with the government. All physicians are eligible to provide services to beneficiaries as long as such services are within the scope of those permitted by their state license.

Reimbursement

Payment to institutional providers is made on the basis of "reasonable cost" (for both Part A and Part B). Reasonable cost is the actual cost to the provider of furnishing a service. Reimbursement is made on the basis of an estimated interim rate agreed to by the provider and the state agency. This rate is subject to an annual retroactive adjustment reflecting the costs actually incurred, as detailed in the annual cost report prepared by the provider.

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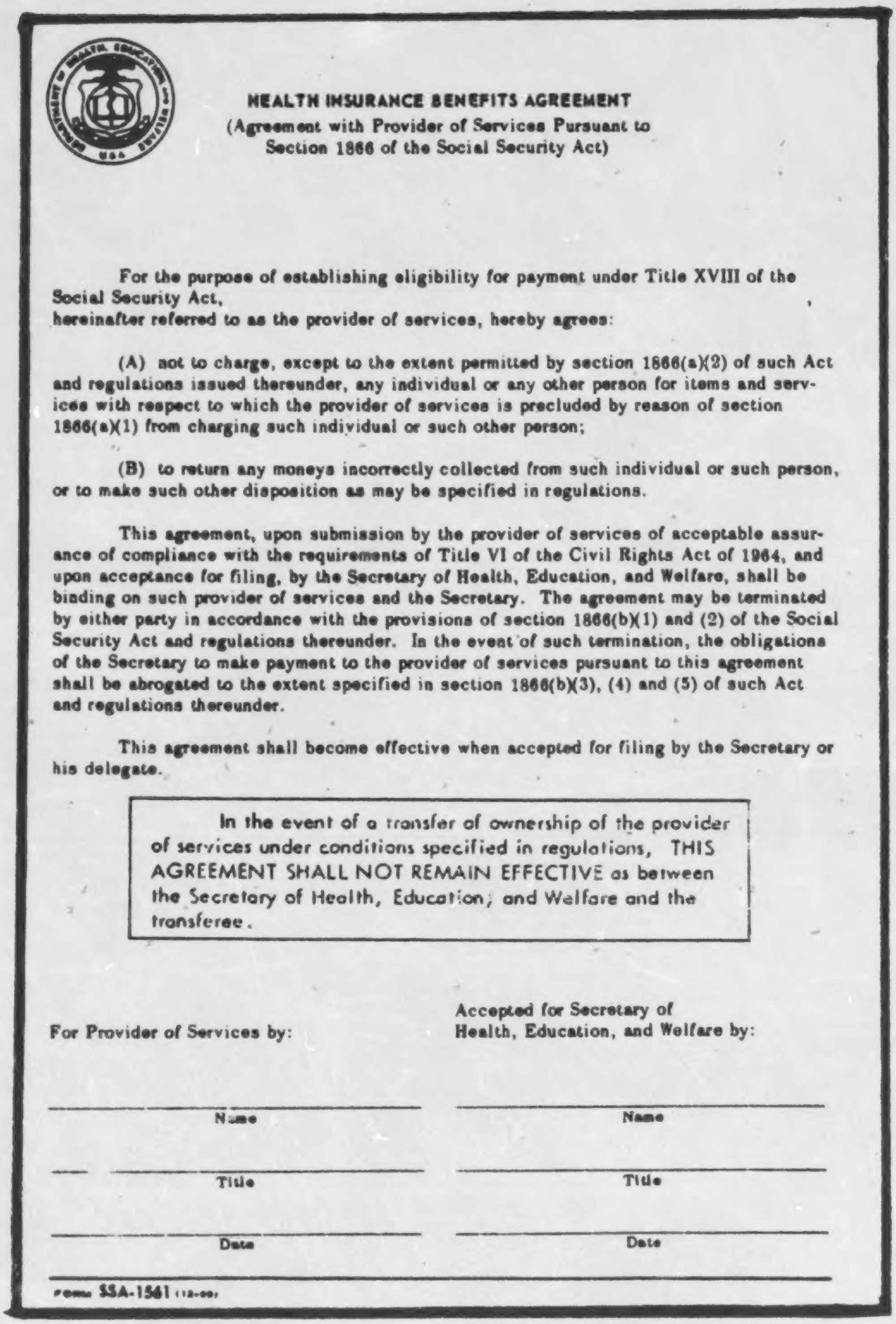
* These requirements, taken together, are referred to as "Conditions of Participation" (when referring to providers of services, and have been specifically developed for each provider category) and as "Conditions for Coverage" (when referring to suppliers of services, other than physicians).

Reimbursement to a physician is made on the basis of "reasonable charge." A reasonable charge is one that is no higher than (a) the physician's customary charge for a particular service, (b) the prevailing charge for that service by other physicians in the area, and (c) the actual charge made by the physician.

The following example (taken from the Part B Intermediary Manual) shows how these factors interrelate:

> The prevailing charge recognized by Medicare for a specific medical procedure ranges from $80 to $100 in a certain locality.
>
> Doctor A's bill is for $75, although he customarily charges $80 for the procedure.
>
> Doctor B's bill is for his customary charge of $85.
>
> Doctor C's bill is his customery charge of $125.00
>
> Doctor D's bill is for $100, although he customarily charges $80, and there are no special circumstances in the case.
>
> The reasonable charge for Doctor A would be limited to $75 since under the law the reasonable charge cannot exceed the actual charge, even if it is lower than his customary charge and below the prevailing charges for that locality.
>
> The reasonable charge for Doctor B would be $85, because it is his customary charge and it falls within the range of prevailing charges for that locality.
>
> The reasonable charge for Doctor C could not be more than $100, the top of the range of prevailing charges.
>
> The reasonable charge for Doctor D would be $80, because that is his customary charge. Even though his actual charge of $100 falls within the range of prevailing charges, the reasonable charge cannot exceed his customary charge in the absence of any special circumstances.



HEALTH INSURANCE BENEFITS AGREEMENT

(Agreement with Provider of Services Pursuant to Section 1866 of the Social Security Act)

For the purpose of establishing eligibility for payment under Title XVIII of the Social Security Act, ,
hereinafter referred to as the provider of services, hereby agrees:

(A) not to charge, except to the extent permitted by section 1866(a)(2) of such Act and regulations issued thereunder, any individual or any other person for items and services with respect to which the provider of services is precluded by reason of section 1866(a)(1) from charging such individual or such other person;

(B) to return any moneys incorrectly collected from such individual or such person, or to make such other disposition as may be specified in regulations.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with the requirements of Title VI of the Civil Rights Act of 1964, and upon acceptance for filing, by the Secretary of Health, Education, and Welfare, shall be binding on such provider of services and the Secretary. The agreement may be terminated by either party in accordance with the provisions of section 1866(b)(1) and (2) of the Social Security Act and regulations thereunder. In the event of such termination, the obligations of the Secretary to make payment to the provider of services pursuant to this agreement shall be abrogated to the extent specified in section 1866(b)(3), (4) and (5) of such Act and regulations thereunder.

This agreement shall become effective when accepted for filing by the Secretary or his delegate.

> In the event of a transfer of ownership of the provider of services under conditions specified in regulations, THIS AGREEMENT SHALL NOT REMAIN EFFECTIVE as between the Secretary of Health, Education, and Welfare and the transferee.

For Provider of Services by:	Accepted for Secretary of Health, Education, and Welfare by:
Name	Name
Title	Title
Date	Date

Form SSA-1561 ([illegible])

Figure 4.3. Agreement with Provider of Services for Participation in Medicare.

Table 4.4

STATE AGENCIES RESPONSIBLE FOR MEDICARE

ARIZONA: State Department of Health, Phoenix, AZ

ARKANSAS: State Department of Health, Little Rock, AR

CALIFORNIA: State Department of Public Health, Sacramento, CA

COLORADO: Department of Health, Denver, CO

CONNECTICUT: State Department of Health, Hartford, CN

DELAWARE: Department of Health and Social Services, Dover, DE

DISTRICT OF COLUMBIA: District of Columbia Department of Human Resources, Washington, D. C.

FLORIDA: Department of Health and Rehabilitative Services, Jacksonville, FL

GEORGIA: Georgia Department of Human Resources, Atlanta, GA

GUAM: Department of Public Health and Social Services, Agana, Guam.

HAWAII: State Department of Health, Honolulu, HI

IDAHO: Department of Environmental and Community Services, Boise, ID

ILLINOIS: Illinois Department of Public Health, Springfield, IL

INDIANA: State Board of Health, Indianapolis, IN

IOWA: State Department of Health, Des Moines, IA

KANSAS: State Department of Health, Topeka, KA

KENTUCKY: Commonwealth of Kentucky State Department of Health, Frankfort, KY

LOUISIANA: Louisiana Health and Social Rehabilitation Services Administration, Baton Rouge, LA

MAINE: Maine Department of Health and Welfare, Augusta, ME

MARYLAND: Maryland State Department of Health and Mental Hygiene, Baltimore, MD

MASSACHUSETTS: Massachusetts Department of Public Health, Boston, MA

MICHIGAN: Michigan Department of Public Health, Lansing, MI

MINNESOTA: State Department of Health, Minneapolis, MN

MISSISSIPPI: Mississippi State Board of Health, Jackson, MS

MISSOURI: State Division of Health, Jefferson City, MO

MONTANA: Department of Health and Environmental Sciences, Helena, MT

NEBRASKA: State Department of Health, Lincoln, NE

NEVADA: State Department of Human Resources, Carson City, NV

NEW HAMPSHIRE: New Hampshire Division of Public Health, Concord, NH

NEW JERSEY: State Department of Health, Trenton, NJ

NEW MEXICO: New Mexico Health and Social Services Department, Santa Fe., NM

NEW YORK: New York State Department of Health, Albany, NY

NORTH CAROLINA: Department of Human Resources, Raleigh, NC

NORTH DAKOTA: State Department of Health, Bismarck, ND

OHIO: Ohio Department of Health, Columbus, OH

OKLAHOMA: State Department of Health, Oklahoma City, OK

OREGON: Department of Human Resources, Portland, OR

PENNSYLVANIA: Department of Health, Harrisburg, PA

PUERTO RICO: Puerto Rico Department of Health, San Juan, P.R.

RHODE ISLAND: Rhode Island Department of Health, Providence, RI

SOUTH CAROLINA: State Board of Health, Columbia, SC

SOUTH DAKOTA: State Department of Health, Pierre, SD

TENNESSEE: Tennessee Department of Public Health, Nashville, TN

TEXAS: State Department of Health, Austin, TX .

UTAH: Department of Social Services, Division of Health,
Salt Lake City, UT

VERMONT: Vermont Department of Health, Burlington, VT

VIRGIN ISLANDS: Territorial Department of Health, St. Thomas,
Virgin Islands.

VIRGINIA: State Department of Health, Richmond, VA

WASHINGTON: Department of Social and Health Services, Olympia, WA

WEST VIRGINIA: State Health Department, Charleston, WV

WISCONSIN: Department of Health and Social Services, Madison,
WI

WYOMING: State Department of Health and Social Services,
Cheyenne, WY

VOCATIONAL REHABILITATION

Vocational Rehabilitation (VR) is a national program that provides services and materials for the rehabilitation of those whose physical or mental disabilities inhibit their employment but who, as a result of VR services, can reasonably be expected to become gainfully employed. The program currently operates under the Rehabilitation Act of 1973.

VR funds are distributed through the Rehabilitation Services Administration of HEW to each state Vocational Rehabilitation agency on a formula grant basis. The state agency, in turn, reimburses those individuals and projects it judges most in need of VR services. Although the majority (75 percent) of program funds are federal, states have considerable autonomy in determining how they will be used.

Many state VR agencies offer services to drug addicts. However, the specific nature of services provided and the severity of addiction required for client eligibility varies widely from state to state. Additionally, service availability often varies within a given state on the basis of relative need. For example, services to addicts are more likely to be offered in a metropolitan area than in a rural one.

Services Covered

Covered services are broadly defined as any item or service considered necessary to render a handicapped individual employable. These may include, but are not limited to:

- Evaluation of rehabilitation potential
- Counseling, guidance, referral and placement services
- Vocational and other training services
- Physical and mental restoration services, including corrective surgery or therapeutic treatment for physical or mental conditions, hospitalization, provision of prosthetic devices and visual services, and diagnosis and treatment for mental and emotional disorders.
- Maintenance during rehabilitation

- Other services or devices related to an individual's employability such as sensory aids, occupational training, licenses, tools, and equipment

Client Eligibility

The 1973 Vocational Rehabilitation Act directed that state VR agencies emphasize services directed to the "severly disabled" and listed specific conditions that automatically fall into this category. Additionally, criteria were established by which an individual not falling into one of the defined categories could be classified as being severely disabled. Substance abuse is not included in the list of severely disabling conditions, however, an individual addict may meet the criteria as "severely disabled."

Provider Eligibility

Generally, a state rehabilitation agency works in conjunction with a drug abuse treatment program to provide additional services to the program's clients. For example, VR may offer employment counseling, skill training, and placement services to an individual who has been treated, or is currently being treated, by a drug program. In some cases, the state agency will place a VR counselor in the program on a full-time or part-time basis. Less frequently, VR will refer addicts to a drug treatment program for services and reimburse the program for such services. State VR agencies have shown some reluctance to expend their limited funds for services provided by another federally supported operation. This is especially true when such services are also made available to individuals without cost.

Establishing a working arrangement with VR normally involves the development of a cooperative agreement, which may or may not be formalized in writing, rather than a contractual arrangement such as required for Medicaid. An agreement of this type outlines the basis for a cooperative relationship between the treatment program and VR, indicating the type of services that will be provided by the respective organizations, at what stage in the treatment process referrals will be made, etc. Further details can be obtained from the local vocational rehabilitation agency in your state.

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS)

CHAMPUS provides comprehensive health care benefits to dependents of active duty Uniformed Services* members, retired members and their dependents, and surviving dependents.

CHAMPUS beneficiaries can obtain reimbursement for both inpatient and outpatient medical care and treatment from civilian medical sources under the basic program. In addition, there is a special program of generally nonmedical rehabilitative benefits for the seriously physically handicapped and moderately or severely mentally retarded spouses and children of active duty members of the Uniformed Services.

CHAMPUS does not process any claims itself. All claims are submitted to, and approved and paid by fiscal administrators, each having responsibility for a particular state (see Table 4.5 for a list of CHAMPUS fiscal administrators).

Client Eligibility

Individuals eligible for CHAMPUS benefits are:

- Spouses and children of members of the Uniformed Services who are serving on active duty (including active duty for training) under a call or order that does not specify a period of 30 days or less, and the surviving spouses and children of deceased active duty members

- Retired and former members of the Uniformed Services who are entitled to retired, retainer, or equivalent pay, and their spouses and children and the surviving spouses and children of such members

Any beneficiary (except an active duty dependent) who, at age 65, has earned and is entitled to hospital benefits under Social Security Medicare loses his CHAMPUS eligibility.

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* The Uniformed Services are the Army, Navy, Air Force, Marine Corps, Coast Guard, and the Commissioned Corps of the Public Health Service and of the National Oceanic and Atmospheric Administration.

Services Covered

In general, any procedures and types of care that are generally accepted as being part of good medical practice, regardless of whether furnished on an inpatient or outpatient basis (other than those specifically excluded by the authorizing legislation) are authorized CHAMPUS benefits.

The general types of conditions covered by CHAMPUS are:

- Medical or surgical conditions
- Nervous, mental, and emotional disorders
- Chronic conditions and diseases
- Contagious diseases

Virtually all services provided by a physician or by other medically related specialists (nurses, physical therapists, etc.) as ordered by a physician are covered (unless specifically excluded by the enabling legislation). Authorized services* of psychologists may be provided without a physician's order.

Further, benefits cover necessary supplies and drugs if administered by a civilian facility, a physician, or procured by the client from a pharmacy (if a prescription is required for their issuance).

Provider Eligibility

Inpatient Facilities

There are two primary eligibility criteria for an inpatient drug abuse treatment facility; these are:

- State licensure

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* Services approved by the fiscal administrator. However, psychologists must be licensed or certified, have a doctoral degree in clinical psychology, and have a minimum of two years of supervised experience in clinical psychology in a licensed hospital, a mental health center, or other appropriate clinical setting as determined by the Director of CHAMPUS.

- Supervision of the program and of client services by a licensed physician

Any inpatient facility wishing to obtain provider status must complete a questionnaire describing the organization and operation of the treatment facility. This questionnaire will be used by CHAMPUS in determining eligibility. If the facility is approved, both the provider and the relevant CHAMPUS fiscal administrator (FA) will be notified. Subsequently, the FA will make an on-site inspection to verify the information in the questionnaire. The specific services covered are determined by the FA and not by CHAMPUS. Therefore, it is important for an approved facility to contact the appropriate FA as soon as possible.

Inpatient facilities are reimbursed on a prevailing or reasonable charge basis. CHAMPUS reimburses the provider for 75 percent of the charge. The remaining portion must be paid by the client.

Outpatient Facilities

The fiscal administrator has full responsibility for approving all outpatient facilities. Therefore, any such facility seeking provider status from CHAMPUS should contact the appropriate FA to obtain the eligibility requirements that it must meet. A list of CHAMPUS fiscal administrators is given in Table 4.5.

Reimbursement

CHAMPUS uses a cost-sharing plan, whereby it pays a share of allowable charges for authorized health care. The customary charges made by the provider and prevailing charges in the community for similar care are considered in determining allowable charges. Unusual circumstances and extraordinary professional effort also are taken into account.

Provider participation requires acceptance of the government's payment plus the client cost-sharing portion (noted below) as payment in full for services provided.

Client Cost-Sharing Portion

Inpatient Care.

- Spouses or children of active duty members: client's share is $25 or $3.70 per day, whichever is greater.
- All others: client's share is 25 percent of the medical facility charges and professional fees.

The government's share is the balance of allowable charges.

Outpatient Care:

A beneficiary's share of authorized charges is the first $50 in a fiscal year (the deductible), plus a percentage of allowable charges above that amount. For a family of two or more beneficiaries filing claims, the maximum deductible in a fiscal year is $100.

- Spouses or children of active duty members: client's share after the $50 or $100 deductible is 20 percent. The government pays the balance of allowable charges.
- All others: client's share after the $50 or $100 deductible is 25 percent. The government pays the balance of allowable charges.

CHAMPUS Information

For further information on CHAMPUS write to:

Director
Attn: Chief, Health Resources Information Division
OCHAMPUS
Denver, Colorado 80240

Table 4.5

CHAMPUS FISCAL ADMINISTRATORS

ALABAMA
Mutual of Omaha Insurance Company
3301 Dodge Street
Omaha, Nebraska 68131

ALASKA
Blue Cross, Washington-Alaska, Inc.
P. O. Box 327
Seattle, Washington 98111

ARIZONA
Arizona Blue Shield Medical Service
P. O. Box 13466
Phoenix, Arizona 85002

ARKANSAS
Arkansas Blue Cross & Blue Shield, Inc.
P. O. Box 1418
Little Rock, Arkansas 72203

CALIFORNIA
California Blue Shield
Post Office Box 7608
San Francisco, California 94120

COLORADO
Colorado Medical Service, Inc.
700 Broadway
Denver, Colorado 80203

CONNECTICUT
Connecticut General Life Ins. Co.
Hartford, Conn. 06115

DELAWARE
Blue Cross & Blue Shield of Delaware, Inc.
201 West 14th Street
Wilmington, Delaware 19899

DISTRICT OF COLUMBIA
(Includes Prince Georges & Montgomery Counties of Maryland, Arlington & Fairfax Counties of Virginia, & the Cities of Alexandria & Falls Church, VA)

Medical Service of the District of Columbia
550 - 12th Street, S.W.
Washington, D. C. 20024

FLORIDA
Blue Shield of Florida, Inc.
P. O. Box 1798
Jacksonville, Florida 32203

GEORGIA
Medical Association of Georgia
938 Peachtree Street, N.E.
Atlanta, Georgia 30309

HAWAII
Hawaii Medical Service Association
P. O. Box 860
Honolulu, Hawaii 96808

IDAHO
North Idaho District
Medical Service Bureau, Inc.
P. O. Box 1106
Lewiston, Maine 83501

ILLINOIS
Mutual of Omaha Insurance Company
3301 Dodge Street
Omaha, Nebraska 68131

INDIANA
Indiana State Medical Association
3935 North Meridian Street
Indianapolis, Indiana 46208

IOWA
Blue Shield of Iowa
Liberty Building
Des Moines, Iowa 50309

KANSAS
Kansas Blue Shield
P. O. Box 239
Topeka, Kansas 66601

KENTUCKY
Kentucky Physicians Mutual, Inc.
3101 Bardstown Road
Louisville, Kentucky 40205

LOUISIANA
Continental Service Life & Health Ins. Co.
P. O. Box 3397
Baton Rouge, La. 70821

MAINE
Maine Blue Cross and Blue Shield
110 Free Street
Portland, Maine 04101

MARYLAND
(Excludes Prince Georges & Montgomery Counties, which are served by the fiscal agent for District of Columbia)

Maryland Blue Shield, Inc.
700 East Joppa Road
Towson, Maryland 21204

MASSACHUSETTS
Blue Shield of Massachusetts,Inc.
P. O. Box 2194
Boston, Mass. 02111

MICHIGAN
Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226

MINNESOTA
Blue Cross & Blue Shield of Minnesota
2344 Nicollett Avenue
Minneapolis, Minn. 55404

Table 4.5 continued

MISSISSIPPI
Mississippi State Medical Assn.
735 Riverside Drive
Jackson, Miss. 39216

MISSOURI
Missouri Medical Service
5775 Campus Parkway
Hazlewood, Missouri 63042

MONTANA
Montana Physicians' Service
P. O. Box 1677
Helena, Montana 59601

NEBRASKA
Blue Shield of Nebraska
Box 3248
Omaha, Nebraska 68103

NEVADA
Nevada State Medical Association
3660 Baker Lane
Reno, Nevada 89502

NEW HAMPSHIRE
New Hampshire-Vermont Physician
Service
#2 Pillsbury Street
Concord, New Hampshire 03301

NEW JERSEY
Medical-Surgical Plan of New Jersey
P. O. Box 262
Newark, New Jersey 07102

NEW MEXICO
New Mexico Blue Cross & Blue Shield, Inc.
12800 Indian School Road, N.E.
Albuquerque, New Mexico 87112

NEW YORK
Blue Cross & Blue Shield of
Greater New York
2 Park Avenue
New York, New York 10016

NORTH CAROLINA
Blue Cross & Blue Shield of
North Carolina
800 South Duke Street
Durham, North Carolina 27702

NORTH DAKOTA
Blue Shield of North Dakota
301 South 8th Street
Fargo, North Dakota 58102

OHIO
Mutual of Omaha Insurance Company
3301 Dodge Street
Omaha, Nebraska 68131

OKLAHOMA
Blue Cross & Blue Shield of Oklahoma
P. O. Box 1738
Tulsa, Oklahoma 74102

OREGON
Oregon Physicians' Service
P. O. Box 1071
Portland, Oregon 97207

PENNSYLVANIA
Medical Service Assn. of Pa.
Blue Shield Building
Camp Hill, PA 17011

RHODE ISLAND
Mutual of Omaha Insurance Co.
3301 Dodge St.
Omaha, Nebraska 68131

SOUTH CAROLINA
Mutual of Omaha Insurance Co.
3301 Dodge St.
Omaha, Nebraska 68131

SOUTH DAKOTA
South Dakota Medical Service, Inc.
711 N. Lake Ave.
Sioux Falls, S. D. 57104

TENNESSEE
Blue Cross, Blue Shield of Tenn.
801 Pine St.
Chattanooga, Tenn. 37402

TEXAS
Mutual of Omaha Insurance Co.
3301 Dodge St.
Omaha, Nebraska 68131

UTAH
Blue Shield of Utah
P. O. Box 270
Salt Lake City, Utah 84110

VERMONT
New Hampshire-Vermont Physicians'
Service
#2 Pillsbury St.
Concord, NH 03301

VIRGINIA
(Excludes Arlington County,
Fairfax County & Cities of
Alexandria & Falls Church,
which are served by the
fiscal Agent for District
of Columbia)

Blue Shield of Virginia
P. O. Box 27401
Richmond, Virginia 23279

WASHINGTON
Washington Physicians' Service
220 W. Harrison St.
Seattle, Wash. 98119

WEST VIRGINIA
Medical-Surgical Care, Inc.
Union Trust Building, Box 1948
Parkersburg, W. Va. 26101

WISCONSIN
Wisconsin Physicians' Service
P. O. Box 1787
Madison, Wisc. 53701

WYOMING
Wyoming Medical Service, Inc.
P. O. Box 2266
Cheyenne, Wyoming 82001

FOOD STAMPS

The Food Stamp Act of 1964 established a program whereby food purchases made in the normal fashion would be subsidized by federal and state governments. The aim of the program is to provide for improved nutrition in low-income households. Eligible households (a family or economic unit, including individuals living alone) can receive coupons through the welfare agency. Recipients pay a percentage of the coupons' face value and may then use them to buy food products at retail stores authorized to participate in the program. The sole criterion for eligibility is income level, provided that all able-bodied adults in the household, except students and those caring for dependent children or disabled adults, are employed or actively seeking employment.

Relevance to Drug Abuse Programs

Amendments to the Act make drug addicts eligible for stamps if they are participating in a treatment program and qualify on the basis of income.

There are three ways in which an addict may obtain benefits:

- A client in an outpatient treatment program, living alone or as a member of a household, may obtain and use food stamps for his household meals. Food stamps are obtained by the individual or household through normal welfare agency procedures.
- A client in a day-care treatment program, living alone or as a member of a household, may obtain food stamps and use them to pay for meals at the program (if the program normally charges its clients for such meals and is authorized to redeem the coupons) as well as for his own meals at home. Food stamps are obtained by the individual or household through normal welfare agency procedures. Programs desiring to participate in this manner must submit an application (Form FNS-252-2) to a field office of the Food and Nutrition Service of the U.S. Department of Agriculture.

- A client living in a residential treatment program may obtain food stamps jointly with the program, for the program to use in providing his meals. In this case the program functions as an "authorized representative" of the Food and Nutrition Service (FNS) and is entitled to receive stamps directly from the issuing agency. The stamps may then be redeemed at designated wholesalers and banks. To be eligible to participate in this way, the client and the program must make a joint application to the local welfare agency. If approved, the program will be issued an Authorization to Purchase (ATP) card and food stamp coupons that can be used to provide meals for that specific client.

A list of regional offices of the Food and Nutrition Service is given in Table 4.6.

The third category may be considered a form of third party payment since provision of food stamps offsets the cost of providing meals to the client. To receive food stamps, the county welfare agency must certify that both the client and the program are eligible. Clients must meet the standard eligibility criteria. Eligibility criteria for the program are: (1) it must have written approval as a treatment program by the Single State Agency; (2) it must be a private, nonprofit organization (separate treatment programs, or "units," within the same organization must apply separately); and (3) it cannot receive federally donated funds in duplication of the Food Stamp Program benefits.

For certification to receive food stamps, the program and its clients must apply to the county welfare agency. Each client applicant must be individually approved as eligible. For authorization to accept and redeem food stamps, the program must apply to a Food and Nutrition Service Field Office of the U.S. Department of Agriculture. Approval of all these applications will mean: (1) the client, in conjunction with the program, is certified to receive food stamps; and (2) the program is authorized to accept the stamps as payment for the meals it provides the client and redeem them at face value (as if it were a retail food store), through similarly authorized wholesalers (for goods or cash) and banks (for cash and credit).

A new food stamps bill is currently being debated in Congress. Although the exact final form of the new bill cannot be predicted, it seems likely that the provision permitting residential treatment facilities to use food stamps jointly with eligible clients will be retained but that it will not be possible to redeem them for cash or credit as an option to food.

Table 4.6

REGIONAL FOOD AND NUTRITION SERVICE OFFICES
OF THE U.S. DEPARTMENT OF AGRICULTURE

Midwest

(Midwest: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, Wisconsin)
536 South Clark Street
Chicago, Illinois 60605
(312) 353-6664

Northeast

(Northeast: Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Puerto Rico, Rhode Island, Vermont, Virgin Islands, Virginia, West Virginia)
729 Alexander Road
Princeton, New Jersey 08540
(609) 452-1712

West Central

(West Central: Arizona (Navajo Nation only), Arkansas, Colorado, Louisiana, Montana, New Mexico, North Dakota, Oklahoma, South Dakota, Texas, Utah, Wyoming)
1100 Commerce Street, Room 5-D-22
Dallas, Texas 75202
(214) 749-2877

Western

(Western: Alaska, American Samoa, Arizona (except Navajo Nation), California, Guam, Hawaii, Idaho, Nevada, Oregon, Washington, Trust Territory of the Pacific Islands)
550 Kearny Street, Room 400
San Francisco, California 94108
(415) 556-4951

Southeast

(Southeast: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee)
1100 Spring Street, N.W., Room 200
Atlanta, Georgia 30309
(404) 526-5131

PRIVATE THIRD PARTY PAYERS

PRIVATE INSURANCE COMPANIES

Health policies are offered by virtually every type of insurance company -- life insurance, casualty, accident and sickness underwriters, and, of course, those formed specifically for the purpose of providing health coverage. Various types of coverage are also offered by unions, by companies formed to provide coverage for specific occupations, and by fraternal organizations.

Insurance companies are generally divided into two types: mutual companies (organized to provide coverage for members at cost), and stock companies (designed to make a profit).

Insurance policies may be issued by either type of company to both groups and individuals. Group policies are written to cover the employees of a firm or the members of an association. One policy is issued for all employees or members wishing coverage. Individual policies, on the other hand, are issued to one person or a family unit.

Private health insurance available at the present time tends to emphasize coverage for inpatient services and services provided by recognized medical practitioners such as physicians and psychiatrists.

Services Covered

Both individual and group policies can offer an enormous range of services. Some may cover only hospitalization, while others may cover doctor's fees, outpatient treatment, psychiatric care, pharmacy charges, or coverage against major disease or surgery. Specific coverage will vary with respect to the particular company writing the policy as well as with respect to the particular type of policy purchased. This is especially true of group policies, as the organization purchasing the policy has considerable latitude in specifying both the type of services to be covered and the extent to which they will be covered (e.g., full coverage or a dollar limit). Group policies, therefore, tend to be customized for the buyer. Thus, two individuals having group medical coverage written by the same insurance company but who are employed by different firms may have very different coverage. As an example, the Michigan Blue Cross/Blue Shield contract with the United Auto Workers specifically covers the treatment of substance abuse, but other policies written for other customers by this carrier do not include such coverage.

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Variability in services covered relates to types of illnesses (e.g., drug addiction may or may not be included in the categories of illnesses covered) and to the specific conditions under which services are provided. Thus, even if drug addiction is included in the list of covered illnesses, a policy may impose specific conditions. Examples of such conditions are: (a) services must be provided by a licensed physician, (b) services must be provided under the direction of a licensed physician, (c) services must be provided to inpatients in an accredited facility. Additional restrictions may further limit services by such factors as length of time, number of encounters, and/or eligibility of dependents (e.g., "up to 18 unless a student").

Although the particular coverage provided and the specific terms and conditions affecting each coverage (e.g., dollar or durational limits) will vary from policy to policy, there are certain basic categories of coverage that are offered by most companies writing health insurance.

Hospitalization

This type of insurance (also referred to as "basic protection") covers care in a hospital for periods ranging from 30 to 365 days or longer, depending on the particular policy.

In general, these benefits help pay for two types of services:

1. Daily room and board in the hospital, routine nursing care and minor medical supplies

2. Other hospital services, such as laboratory tests and X-rays, anesthesia and its administration, use of operating room, drugs and medications, and local ambulance service (These services may be referred to as miscellaneous or ancillary expenses.)

Frequently the benefit of these additional services is expressed as being so many times the room and board benefit. For example, if the room and board benefit is $50 a day, the additional expense benefit may be ten times this amount, or $500.

Major Medical

This type of coverage provides protection against the costs of serious and prolonged illnesses. The maximum amount such a policy pays varies. Some pay up to $20,000; some up to $250,000;

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some have no limit at all. A high-benefit policy is popularly known as "catastrophic coverage." Major medical benefits cover virtually every type of care and treatment prescribed by a physician, both in and out of the hospital, including:

- Hospital services
- Physician's treatment and specialist's consultation and care
- Surgery
- X-ray and laboratory services
- Anesthesia and its administration
- Private duty nursing
- Prescribed drugs and medicines

Both hospitalization and major medical insurance generally have a deductible amount that is paid by the insured or by the "Basic Protection" insurance before major medical benefits start. This can range from $50 to $1,000 or more, depending on the policy.

Hospital Indemnity

These policies reimburse the insured for the actual cost of the medical services received up to the dollar limit specified in the policy, less any deductible amount. Some insurance companies write medical coverage on a "valued" basis, whereby the insured receives a specified dollar amount for each day during which he is hospitalized up to a maximum number of days, irrespective of the costs actually incurred.

Additional terms and conditions generally used by private insurers that serve to limit reimbursement are:

> Coinsurance, in which the insurance company and the insured each pay a percentage of the cost of treatment. For example, under the terms of the policy, the insured service recipient may pay 20 percent and the insurance company 80 percent of the costs incurred.
>
> Deductible, which specifies an amount of covered expenses that must be incurred by the insured before benefits become payable by the insurer. For example, the insured may have to pay the first $100.

Client Eligibility

Coverage is dependent on the payment of premiums, either by the individual policyholder or the group policyholder.

Client eligibility is automatic in the case of a group policy (i.e., all members of the group must be covered by the underwriter). However, in the case of an individual, eligibility might be related to factors such as age, physical condition, or family medical history.

An important consideration in regard to private insurance coverage for drug addicts will be the individual's employment status. Since an addict is most likely to use his income to support his habit and provide for the basic necessities, he probably does not have medical insurance unless it is provided by his employer. Therefore, determination of the proportion of your client population that is employed is basic to assessing the likelihood of obtaining reimbursement from private carriers.

Provider Eligibility

Specific provider eligibility criteria will vary from carrier to carrier. However, an individual provider generally must be a "licensed practitioner" and an institutional provider must be state licensed, accredited by an organization specified by the carrier, or (in the absence of either of these) approved on the basis of company-specific standards. For example, the aforementioned Michigan Blue Cross/Blue Shield contract with the UAW requires that residential and outpatient substance abuse programs comply with the requirements that they--

> (1) be licensed by the Michigan Department of Health; (2) be accredited by the Joint Commission on Accreditation of Hospitals; and (3) are in compliance with Blue Cross and Blue Shield of Michigan's qualifications for approval.

In order to be approved as a provider by a private carrier, you will generally have to submit a formal application, together with any supporting material specified by that carrier. Note: Such approval must be obtained from each carrier and the specific requirements and procedures will vary with each carrier. Most typically, the information required relates to:

- Identification of the facility (name, address, phone, etc.)
- Type of credentialing already obtained
- Type of services provided
- Size and professional qualifications of staff
- Fee schedule
- Client population

Additionally, many carriers will require an on-site inspection by their representative.

Blue Cross and Blue Shield

Blue Cross and Blue Shield are a loosely knit group of private nonprofit insurance companies (formally referred to as "Plans"). Each plan is a separately administered, local organization authorized to use the Blue Cross or Blue Shield name and emblem. Although Blue Cross and Blue Shield are separate programs, each having its own national association, in most areas they cooperate closely with one another.

Blue Cross provides coverage for hospital expenses that include hospital room plus other related services such as laboratory, X-ray, medication, and operating room. Blue Shield covers such physician's services as office visits (if connected with a hospital-related admission), surgical fees, etc.

The various Blue Cross and Blue Shield Plans operate much the same as other private insurance companies. They have the same degree of inter-organizational variability with respect to services covered and criteria that determine client and provider eligibility. However, with respect to provider eligibility, nearly all require state licensure and/or accreditation by a recognized organization such as JCAH or American Osteopathic Association (AOA). Many also require a certificate of need from the local department of public health specifying that the provider is necessary in the community and not duplicating services offered by others.

A major distinction between Blue Cross and commercial insurance companies is in the nature of the benefits payments. Blue Cross plans provide "service benefits" as opposed to "indemnity" and "valued" benefits. Service benefits pay 100 percent of the costs of those services covered in this manner. Some services, however, are covered on a regular fee-schedule basis, whereby the insured is reimbursed for the cost of the service up to a fixed dollar limit.

Another distinction between Blue Cross and commercial carriers relates to the nature of the hospital-carrier relationship: a contractual relationship is generally established whereby the type of services to be covered on a service benefits basis, and the reimbursement for each, are agreed to by the respective parties.

Mandatory Coverage for Drug Addiction

In an attempt to ensure medical coverage for drug addiction on the part of private carriers, bills have been introduced in several state legislatures that would mandate the inclusion of some type of drug abuse treatment benefits in group health insurance policies offered in the state. As of April 1976, five states (Hawaii, Minnesota, Nevada, North Dakota, and Wisconsin) had enacted such legislation and it was pending in five others (Alaska, Arkansas /under study/, Kansas, Michigan,* and South Dakota). The nature of the benefits required by states having this type of legislation is given in Table 4.7.

HEALTH MAINTENANCE ORGANIZATIONS

Health Maintenance Organizations (HMOs) are organized systems of health care that provide or otherwise assure the delivery of an agreed-upon set of comprehensive health maintenance and treatment services to a voluntarily enrolled group of individuals in a geographic area. Enrollees are charged a fixed, prenegotiated fee (capitation payment) that entitles them to the services offered by the HMO. The first sentence above describes the four principal characteristics of an HMO, each of which needs to be explained more fully.

An organized system of health care should provide the services of physicians or other health professionals, with the services of inpatient and outpatient facilities, and any other health services that a particular population might need. The system is organized in such a way as to give the enrollee an efficient and effective entry into the health care system. It also promises continuity of care for the enrolled population through linkages among the components of the system.

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* Michigan, however, currently requires that all individual health policies offer inpatient treatment for alcoholism and drug abuse as a benefit option and that all group policies offer both inpatient and outpatient treatment as benefit options.

Through comprehensive health maintenance and treatment services, the HMO provides (or arranges for the provision of) the health services that a population might require, including primary care, emergency care, and rehabilitation for chronic and disabling conditions.

An agreed-upon set of services means that the consumers and the HMO agree upon the services that will be purchased from the HMO in return for the membership fee. Since some HMOs may have groups of enrollees paid for by Medicare, or Medicaid, or by employer-employee arrangements, the benefit schedule for population groups may differ.

The enrolled group refers to those individuals or groups of people who voluntarily join the HMO through a contract arrangement in which the enrollee agrees to pay the HMO fixed monthly or other periodic payment (or have it paid on his behalf). The enrollee agrees to use the HMO as his principal source of health care if he becomes ill or needs care. The contract is for a specified period of time (most typically, one year).

The concept of the health maintenance organization grew from the success of a variety of medical foundations and prepaid group practice organizations in various parts of the United States that are now providing health care services for more than 7 million persons. Some of the better known examples of existing HMOs are the various Kaiser Foundation Health Plans, the Health Insurance Plan of Greater New York, the Group Health Cooperative of Puget Sound, in Seattle, Washington, and the Group Health Association of Washington, D.C.

An HMO can be organized and sponsored by either a medical foundation (usually organized by physicians), by community groups who bring together various interested leaders or organizations, by labor unions, by a governmental unit, by a profit or nonprofit group allied with an insurance company or some other financing institution, or by some other arrangement. The HMO may be hospital-based, medical-school-based, or be a freestanding outpatient facility or group of such facilities.

There are two basic types of HMOs--group practice associations and independent practice associations. Group practice associations provide services through physicians practicing together in an organized group, generally within the same facility. Independent practice associations are organizations of physicians who operate out of their own independent offices but who are coordinated through some type of organizational structure that provides administrative and financial management functions.

The federal government has recognized that HMOs represent a potentially valuable means of providing medical services to significant segments of the population. The Health Maintenance Organization Act of 1973 (P.L. 93-222) was signed into law on December 29, 1973. This act encourages the development of HMOs by authorizing temporary federal financial support in the form of grants, contracts, or loan guarantees for feasibility studies, planning, initial development, and expansion of HMOs. Additionally, P.L. 93-222 requires that employers who are governed by the federal minimum wage law and who employ 25 or more people include the option of membership in an HMO as part of any health benefits plan offered employees.

P.L. 93-222 requires that in order to qualify for assistance, an HMO must offer a comprehensive set of basic health care services, including treatment for drug and alcohol abuse. The federal regulations governing implementation of the law list services that an HMO must either provide or arrange to have provided.* Required services include:

> (5) Diagnosis, medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs:
>
> (i) Diagnosis and medical treatment shall include detoxification for alcoholism or drug abuse on either an outpatient or inpatient basis, whichever is medically determined to be appropriate, in addition to treatment for other medical conditions;
>
> (ii) Referral services may be either for medical or for nonmedical ancillary services. Medical services shall be a part of basic health services; non-medical ancillary services (such as vocational rehabilitation, employment counseling), need not be a part of basic health services;

The above referenced requirements are significant for a drug treatment program; they require a new or expanding HMO seeking federal financial assistance to make the specified drug abuse treatment services available to its members, either directly or through an arrangement with an "outside" facility. Therefore, an HMO may choose to contract for such services with a drug treatment program and thus serve as a third party payer to the drug program. In such a case, provider and service eligibility requirements would be set by the particular HMO involved.

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* Section 110.102, *Federal Register,* 39 F.R. 37308, October 18, 1974.

NATIONAL HEALTH INSURANCE

For the future, National Health Insurance (NHI) may provide a means of making health care services available to the general population through a federally assisted, prepaid benefits system. Many different proposals for NHI have been advanced but five bills are considered major proposals. Table 4.8 illustrates the five bills, their authors, and the extent to which drug abuse treatment is provided for by each, on both an inpatient and outpatient basis. An examination of Table 4.8 shows that only the Corman-Kennedy and Ulman bills specifically and clearly cover the treatment of drug addiction.

All of the NHI bills are still "in committee" and thus subject to change. Therefore, the information presented in Table 4.8 must be regarded as tentative and may or may not bear any relationship to any final NHI legislation.

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Table 4.7

SUMMARY OF BENEFITS ALLOWABLE UNDER STATE LEGISLATION THAT MANDATES INSURANCE COVERAGE FOR TREATMENT OF DRUG ABUSE (AS OF OCTOBER 1975)

State	Bill No. and/or Title	Date Passed	Dollar Benefits	Days of Care	Location of Care	Deductible/ Co-Insurance
Nevada	Senate Bill #588	1975	Basic policy: $1,000	Not to exceed 10 days	Licensed hospital	None
				Not to exceed 30 days	Treatment facility or health facility certified by Bureau of Alcohol and Drug Abuse	
			Major Medical Policy: Maximum benefits: $800	Outpatient treatment for 180 days (If received inpatient, benefits must commence within 7 days.)	Either licensed hospital and/or treatment facility or health facility certified by Bureau of Alcohol and Drug Abuse	None
North Dakota	House Bill #1596	1975	None	70 days in any calendar year for inpatient; 140 days in any calendar year for partial hospitalization "combination" of inpatient and partial hospitalization; each day of inpatient equals 2 days of partial hospitalization.	Licensed treatment facility	None

Table 4.7 (Continued)

State	Bill No. and/or Title	Date Passed	Dollar Benefits	Days of Care	Location of Care	Deductible/ Co-Insurance
Minnesota	Accident & Health Insurance	1973	At least 20% of total patient days as allowed by policy	No less than 28 days each calendar year	Licensed hospital; residential primary treatment program as licensed by state and as recommended by M.D.	None
Wisconsin	Insurance Bill	1971		30 days in any calendar year for inpatient	Licensed hospital	None
			$500 in any 12 month period for outpatient		Hospital or out-patient treatment facility; or M.D. at any location	None

Source: Survey data from interviews with State Legislative Research Councils, by H-2, Inc.; Cary, N.C.

Table 4.8

SUMMARY OF INSURANCE COVERAGE FOR THE TREATMENT OF DRUG ABUSE AS CONTAINED IN FIVE NATIONAL HEALTH INSURANCE PROPOSALS

Number and Name of Legislation	Author	Coverage for Drug Abuse	
		Inpatient	Outpatient
H.R. 1, National Health Care Services Reorganization and Financing Act	Ulman	Excluded unless patient is in an "acute" condition	Yes (10 visits per year and subject to co-payment)
H.R. 21 (S.3), Health Security Act	Corman, Kennedy	Yes	Yes
H.R. 5990, National Health Care Act of 1975	Burleson	Not Clear	Not Clear
H.R. 6283, Comprehensive National Health Care Act of 1975	Young	*	*
H.R. 6222, Comprehensive Health Care Insurance Act of 1975	Fulton	**	**

* Drug abuse not specifically mentioned but presumably covered under mental health provisions: 45 days of inpatient care per year plus the equivalent of 50 outpatient visits per year.

** Drug abuse care would presumably be covered if acceptable to insurance carriers.

Source: Model Health Insurance Benefit Plan for the Treatment of Drug Abuse, H-2, Inc., Cary, N.C., for NIDA, December 17, 1975.

SECTION 5

CONFIDENTIALITY

CONFIDENTIALITY: A PROFESSIONAL AND LEGAL OBLIGATION

Drug abuse treatment programs have both a professional and legal obligation to preserve the confidentiality of client information.

Professional Obligation

As a professional organization collecting information of a personally-sensitive nature, programs must ensure that such information is treated in a confidential manner to protect their clients' right to privacy. The release of information regarding a history of drug abuse may be injurious to a client's rehabilitation, employability, and/or social well-being. It is the responsibility of the program to make certain that the client is not disadvantaged because of participation in treatment. Further, since a drug treatment program operates as a provider of medical services, client information becomes a medical record and must be treated accordingly.

Legal Obligation

The federal government recognizes the client's right to confidentiality. The right to confidentiality is specified in P.L. 92-255 (The Drug Abuse Office and Treatment Act of 1972), Section 408 as amended by P.L. 93-282 and in the Federal Regulations Part 2, Title 42, Confidentiality of Alcohol and Drug Abuse Patient Records. These regulations were published in the Federal Register of July 1, 1975 (pp. 27802-21). A detailed understanding of these regulations can be obtained through the self-instructional course in confidentiality prepared by the National Drug Abuse Center.

Applicability of the confidentiality regulations is extremely broad as they are relevant to any program receiving direct or indirect financial assistance from the federal government. Specifically, these regulations apply to any drug abuse function that:

- in whole or in part is conducted by grant, contract, or otherwise by any federal agency;

- in whole or in part must be licensed, registered, approved, or authorized for the lawful conduct of business by any federal agency;
- is assisted by funds supplied by any federal agency either directly by grant, contract, or otherwise, or indirectly by funds supplied by a federal agency to a state or local government through contracts, grants, general or specific revenue sharing;
- has been given tax exempt status by the Internal Revenue Service, or is allowable as an income tax deduction when contributions are made to it.

Where state regulations regarding confidentiality exist, they may supersede federal regulations only when the state regulation is more stringent. Otherwise no state law may either authorize or compel any disclosure prohibited by the federal regulations.

The federal regulations apply to all client records maintained by a program. "Records" are defined as "all oral communications and all written materials related to both past* and current clients." Records and information covered would include those relating to a client's identity, diagnosis, prognosis, treatment, program participation, or other information on the status of the client.

PROTECTING CLIENT'S RIGHT TO PRIVACY

Drug treatment programs are responsible for protecting the client's right to privacy by limiting disclosure, obtaining written consent from clients, establishing administrative procedures for ensuring confidentiality, and maintaining adequate security precautions. Penalties for violation are $500 for the first offense, and $5,000 for each subsequent offense.

Limiting Disclosure

The program must prevent access to client information by unauthorized persons. Only those individuals having a professional need to know, a legal right to know, and (where necessary) written consent of the client may obtain client information, and then only when the specified conditions are met. The nature and extent of the information released to authorized individuals or organizations is restricted to that which is minimally necessary to fulfill the purpose for the disclosure. Authorization does not mean carte blanche access to client information.

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*"Past clients" refers to individuals who received treatment after 3/21/72 and whose case files are subject to the regulations.

Obtaining Client Consent

The client must give his written, informed consent for release of information except under certain prescribed circumstances.* Informed consent means that the client fully understands the reasons for the disclosure and agrees to the release of the information. Additionally, the client's consent must be given freely, voluntarily, and without coercion. This is accomplished by having the client sign a written consent form specifying the following:

- Name of client
- Name of program making disclosure
- Name or title of person or organization to which disclosure is to be made
- Extent or nature of information to be disclosed
- Purpose or need (reason) for disclosure
- Statement that consent is subject to revocation, by the client, at any time (unless the provider has already taken action based on having obtained consent) and the specific time upon which the consent will expire without express revocation or renewal
- Signature of client and/or other signature as required**
- Date consent signed

---

*The specific circumstances under which client information can be released without prior consent are noted under the subtopic "IMPLICATIONS FOR THE PROGRAM" of this section.

**If the client is a minor and there is no state law permitting minors to obtain medical services without the approval of a parent or guardian, the consent form must also be signed by the client's parent or guardian.

An example of a consent form that you may want to use or modify is given in Figure 5-1.

IMPLICATIONS FOR THE CLIENT

The client may be apprehensive about consenting to the release of information. Clients may be reluctant to consent to releasing information about their participation in a drug abuse treatment program because of their concern regarding potential negative consequences that may occur as a result of the disclosure.

Clients who are employed when they enter treatment may fear that if their employers learn of their drug problem, they might be fired, moved to a less sensitive job, or that their potential for advancement might be diminished. Other apprehensions could be loss of a security clearance or general anxiety about being socially ostracized. Welfare recipients may fear loss of this source of income. A woman on welfare may fear that she will be declared an "unfit" mother and her children taken from her.

Clients or parents of clients who have insurance that covers drug abuse treatment may be reluctant to release information to the insurance company because they might then be considered a bad insurance risk.

Minors living in states where they may legally obtain medical treatment without parental consent, but whose parents may have private insurance or other third party coverage that will pay for their treatment, may be unwilling to attempt to obtain such reimbursement as it would require them to inform their parents of their treatment in order to obtain the needed insurance forms.

All of these fears are very real to some clients, and these situations can occur. It is the responsibility of the drug treatment program to assist the client in weighing the potential benefits and liabilities involved in consenting to release information. Remember, it is the client's right to refuse to give consent, for any reason, and he must not be coerced into giving it.

IMPLICATIONS FOR THE PROGRAM

Adherence to the federal confidentiality regulations affects a program in two basic ways--it creates a need to develop appropriate administrative procedures and establishes the necessity of providing for the physical security of client records.

Administrative Procedures

The program should develop written procedures for regulating and controlling access to client information. These procedures should establish methods for processing information obtained at various data collection points (registration, counseling, medical examinations, methadone dispensary, etc.), limiting access to client information, and providing for accountability.

One staff member should be designated to process inquiries and requests for client information. This person should be trained in the implementation of the confidentiality regulations and should be directed to maintain a record of all requests for information. Such a record should show who requested the information, the nature of the information requested, and the date of the request.

All inquiries for client information should be in writing. Exceptions to this are bona fide medical emergencies and circumstances in which an individual who is on medication, prescribed by a program, is in a situation where he is unable to provide written consent to his treatment program (e.g., traveling, hospitalized, incarcerated) and requires continuation or modification of his medication. In all of the above types of situations a written record after the fact is required to document the disclosure. All inquiries and client consent forms must be in conformity with federal and state regulations.

Administrative procedures should also be developed to cover the specific instances under which client information may be released without consent. These are:

- In case of medical emergencies
- For the purpose of scientific research, program audit or evaluation (as long as individual client identity is not disclosed by the recipients of this information and the information is not used for action against any individual)
- If authorized by a court order

  NOTE: A court order based on the authorizing legislation for the confidentiality regulations--21 U.S.C. 1175 and 42 U.S.C. 4582--only nullifies the prohibition against disclosure, it does not compel disclosure. A court order or provision of an order based on some other authority, or a subpoena, or other appropriate legal process, is required to compel disclosure.

- In the case of a minor who, in the opinion of the program director, lacks the capacity to make a rational decision on whether to consent to the notification of a parent or guardian, if such notification is necessary due to a "substantial life-threatening situation." In such a case, the relevant facts may be communicated to a parent or guardian.

Federal regulations permit the release of client information to third party payers only with the client's written consent. Such disclosure is limited to information that is reasonably necessary for the discharge of the contractual obligations of the third party payer. Where such third parties maintain records that identify the clients, they also must abide by the same regulations governing treatment programs. Therefore, they are also prohibited from unwarranted disclosure of client data. *It is the responsibility of the treatment program to make certain that both public and private third party payers understand that they are subject to the confidentiality regulations.*

The federal confidentiality regulations state that the following caveat (or one substantially the same) must accompany the release of client information to any individual or organization not directly subject to those regulations:

> This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42-CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Physical Security

Programs must take appropriate precautions for the security of records. Records containing any information pertaining to clients must be kept in a secure room, or locked file cabinet, safe, or similar container when not in use. Access to files should be controlled by one staff member. The records should reside in a secure file (preferably a central file), and there should be a sign-out procedure if possible. Records should be signed out in the morning and returned to the secure file prior to the close of business each day. If a record is kept out overnight, it should be stored in a locked file.

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Client-related documentation that is subject to service audit* should be maintained in such a manner as to preclude identification of individual clients.

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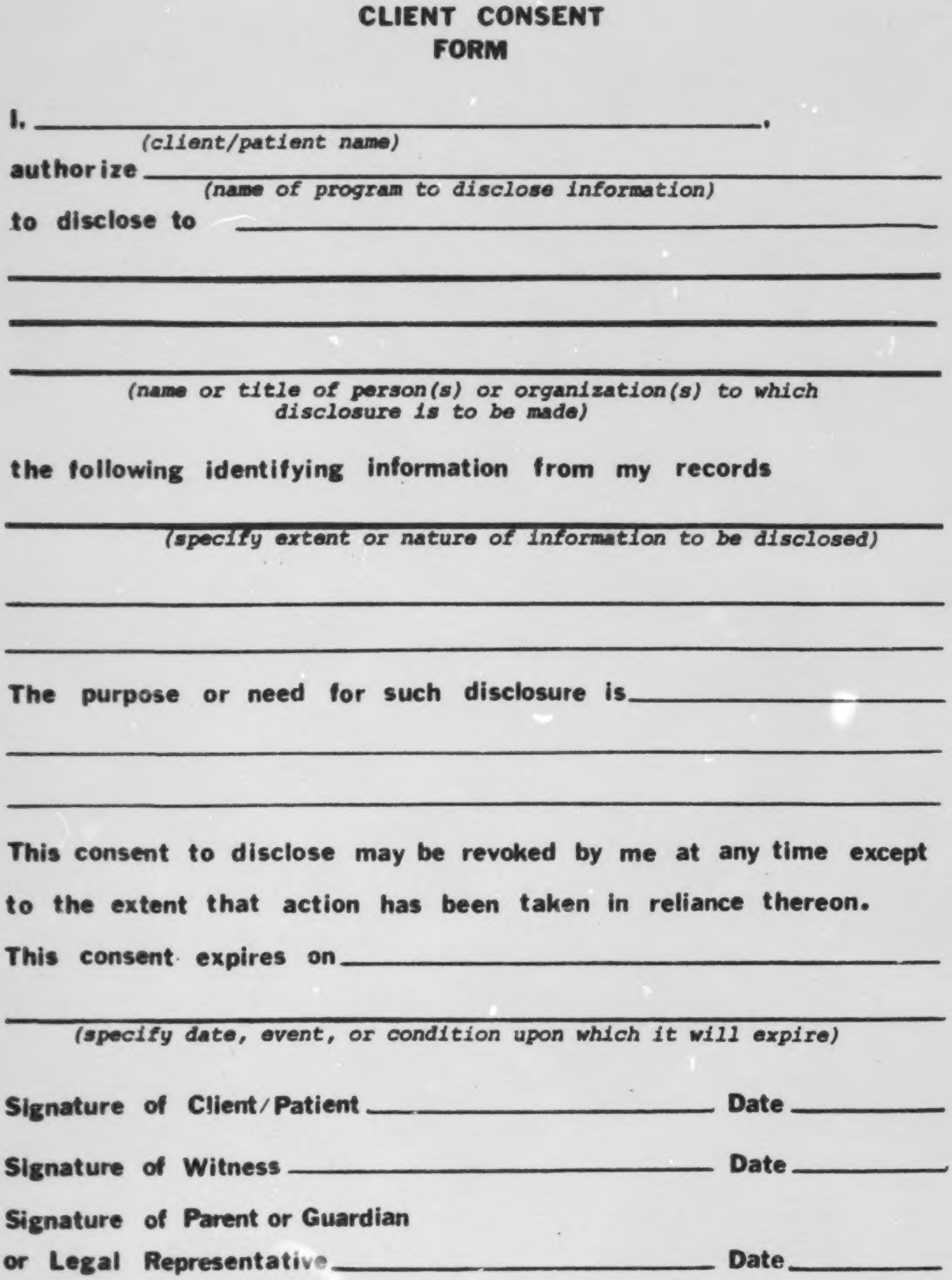
*The item "service audit" as used here refers to governmental review to verify compliance with legal requirements.



CLIENT CONSENT
FORM

I, ____,
(client/patient name)

authorize ____
(name of program to disclose information)

to disclose to ____

____

____

____
(name or title of person(s) or organization(s) to which disclosure is to be made)

the following identifying information from my records

____
(specify extent or nature of information to be disclosed)

____

____

The purpose or need for such disclosure is ______________________

____

____

This consent to disclose may be revoked by me at any time except to the extent that action has been taken in reliance thereon.

This consent expires on ____

____
(specify date, event, or condition upon which it will expire)

Signature of Client/Patient ______________________ Date ____________

Signature of Witness ______________________ Date ____________

Signature of Parent or Guardian
or Legal Representative ______________________ Date ____________

Figure 5.1. Sample Client Consent Form

*Prepared by the Connecticut Alcohol and Drug Council

SECTION 6

ADMINISTRATIVE CONSIDERATIONS

Third party payments and financial management procedures are closely interrelated. Improved financial management will generally increase a program's potential for collecting third party payments. Income from third party payments can help to broaden the base of financial support for the program. The interrelationship between financial management and third party payments is clear in the Guidelines and Regulations for Health Services Funding discussed in Section 2.

Thus, third party payments impact broadly on the administrative and financial management procedures of a program. This section discusses these implications in two areas of program management: policies and procedures and recordkeeping. Other considerations, development of a fee schedule and billing and collection procedures will be discussed in Section 7.

POLICIES AND PROCEDURES

Certain basic questions must be answered before a program can effectively implement a third party payments system. These are:

1. What are we trying to accomplish?

   Will the program undertake a major effort to establish a third party billing and collection procedure? What percentage of its total revenue will the program expect from third parties? What are the sponsoring agency's expectations? What is the current experience with the client population? Is the program undertaking this action merely to meet federal, state, or local requirements or on the basis of well-planned financial management decisions?

2. What resources should be utilized?

   Will external resources be used in billing and collection activities? Are any resources available from a major institution that backs up the program? Will a major investment be made in people and equipment in order to effect a billing and collection program? Who in the program's organization will be primarily responsible for this function?

3. How well must it get done?

   What level of success is expected by the program director and the governing body? How will accomplishment be measured?

Answers to the above questions will provide the basis for a sound management structure for implementing a third party payments system.

Once the decision is made to seek third party funds, basic management decisions are required in the areas of planning, organizing, and managing the collection of revenues from clients or third parties. Specific policies must be developed relative to the implementation and use of a third party payments system and procedures for executing them must be developed. These policies will relate to such factors as:

- Nature and extent of charges to be made for services rendered
- Procedure for obtaining third party information from clients
- Procedure for obtaining client consent to release information to third party
- Protection of client information
- Use of third party revenues
- Provider eligibility requirements
- Maintenance of financial records
- Development of a billing and collection system

RECORD KEEPING

The third party reimbursement mechanism requires paperwork. Third parties simply will not pay for services unless they have evidence that the service was performed, that it is covered by the policy, that the recipient is eligible, and that the provider was qualified. The insuror also wants to be sure that the charges are reasonable.

Part of the input to this system will be from records that identify eligibility completed at the time of the client's entry into the program. An accurate record of eligible encounters must back up each billing. This information could be maintained on the same record, one that identifies eligible services and payers and also provides space to record visits and billings to the payers. A separate set of records should be maintained to record receipt of payments from third party payers and clients.

Requirements regarding the identification of clients who are eligible for third party assistance are outlined in the Health Services Funding Regulations, as follows:

> 50.105
>
> (e) An ongoing procedure to identify all persons served who are eligible for third-party reimbursement.
>
> Discussion
>
> Projects must establish and maintain standard registration and record-keeping procedures to identify and update information on the third party coverage and eligibility status of individual project users. These procedures should be contained in procedural manuals which are updated as needed. The procedures should include those needed to:
>
> (1) Obtain accurate information on such items as age, residence, income, family size, present third party coverage, etc., without offending the dignity of the patient.
>
> (2) Verify the information as frequently as needed (at least annually) to maintain accurate information.
>
> (3) Inform patients of their rights and responsibilities in the area of third party coverage and assist them to formally apply for any applicable coverage(s).

The HSF Regulations also identify additional information that should be recorded as part of a sound management system: financial data, registration data, staff productivity, and services utilization data.

> Financial data and reports. Projects should maintain sufficient financial records and statistical data for proper determination of costs. Standardized definitions, accounting, statistics, and reporting practices which are widely accepted in the health care and social therapeutic fields should be used or followed. Cost information should be current, accurate and in sufficient detail to support operation of the project, satisfy national reporting requirements and determine rates applicable to third party payors. This includes all ledgers, books, records and original evidences of costs (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, valuation of in-kind contributions, labor time cards, payrolls, bases for allocating

costs, etc.). Projects should develop and maintain internal controls to insure the integrity and adequacy of its systems and procedures. An annual fiscal audit by an independent auditing firm should be considered an effective management tool as well as substantiating the project's own cost figures when negotiating with third party payors.

Registration and other patient data information systems. Appropriate medical record, registration and encounter (or clinic visit record) systems should be instituted in order to allow the project to collect, record and maintain current information on patients, including patient identification, third party payor coverage, ability to pay for services, and actual service utilization.

Information on direct service personnel productivity and services utilization in order to allow for an assessment of overall project efficiency.

Types of Records

A program must maintain written records that document clients' eligibility status, payer information, services provided and their costs, and billing and collection status.

Client Third Party Eligibility Status

Certain basic data relevant to the client's eligibility for third party reimbursement should be obtained at the point of intake. The type of information to be obtained from the client should include:

- Client's knowledge of his eligibility for third party reimbursement
- Identification of any physical or mental impairment or disability
- Age, sex, and relationship of other members of client's family
- Family income and source(s)
- Additional monetary resources available to client's family

A sample form for recording this information is shown in Figure 6.1.

Encounter Records

Encounter records identify what services were provided on what dates and by whom. For general program purposes it is a good idea to keep this information, but it is essential that it be kept for preparing bills and in providing documentation of charges to clients and third party payers. An example of an encounter form is shown in Figure 6.2.

Billing and Collection Records

These records document a program's third party reimbursement efforts. Programs should establish an accounts receivable system to show which bills have been paid and which have not.

A final set of records show the program's third party reimbursement payments and their percentage of total income. These records should include the different sources of payment. This information will help in analyzing cost structures and in evaluating and updating rate schedules. The information is also necessary to evaluate and monitor the efficiency of the third party reimbursement system.

SUMMARY OF ADMINISTRATIVE CONSIDERATIONS

Use of the third party payment system will, indeed, place additional demands upon your program. Intake procedures may have to be revised. Extra care in documentation and validation, as well as strict adherence to the use of release forms will be required.

However, there are many positive outcomes to developing third party payments. Third party payers supply needed revenue. The incorporation of third party payments into your program can provide the opportunity for self-assessment, and offers a chance to institute policies and procedures that can enhance the efficiency and credibility of your program.

CLIENT THIRD PARTY ELIGIBILITY DATA

NAME: LAST, FIRST, MIDDLE INITIAL

DATE:

PHONE:

ADDRESS: STREET, CITY, STATE, ZIP CODE

1.		AGE	SEX
CLIENT			
OTHER FAMILY MEMBERS			

3. FAMILY INCOME

ANNUAL:
$

MOST RECENT QUARTER:
$

2. TO YOUR KNOWLEDGE, ARE YOU ELIGIBLE FOR ANY OF THESE PROGRAMS?

	YES	NO	UNCERTAIN
MEDICAID	☐	☐	☐
TITLE XX	☐	☐	☐
PERSONAL INSURANCE	☐	☐	☐
COMPANY: ____________			
GROUP INSURANCE	☐	☐	☐
COMPANY: ____________			
OTHER:	☐	☐	☐
____________			
____________			

4. SOURCE OF INCOME:

☐ SSI ☐ AFDC ☐ OTHER

☐ EMPLOYMENT: NAME ____________
ADDRESS ____________
____

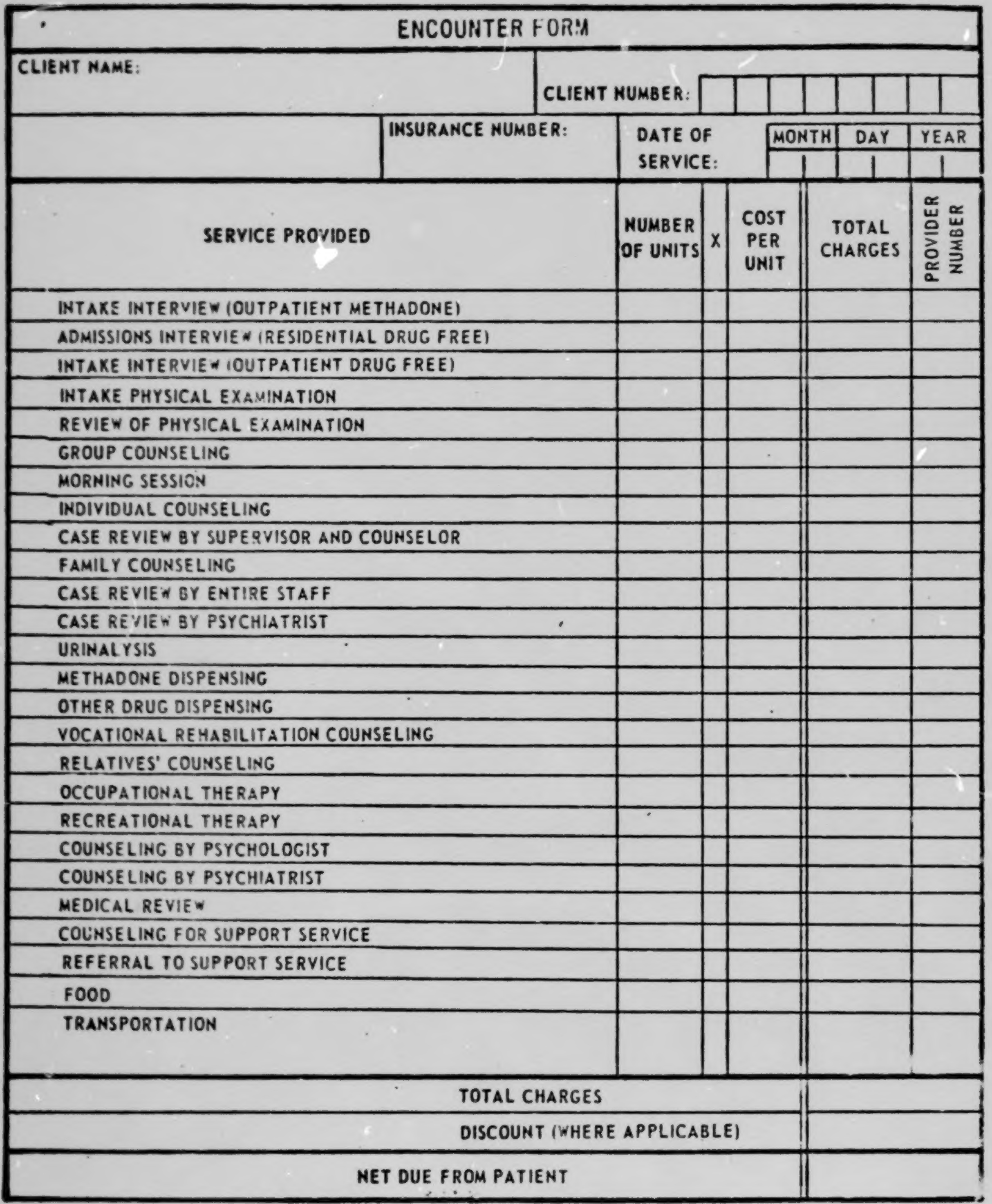
☐ OTHER (LIST): ____________
____

5. FAMILY RESOURCES:
☐ OWN HOME: $ ________ EQUITY
☐ OWN CAR: $ ________ EQUITY
☐ CASH: $ ________ AMOUNT
☐ OTHER (DESCRIBE): ____________
____

6. ARE YOU CURRENTLY DISABLED? (DESCRIBE):

Figure 6.1

*Source: NIDA Financial Management Seminar by Macro Systems, Inc.



ENCOUNTER FORM

CLIENT NAME:

CLIENT NUMBER:

INSURANCE NUMBER:

DATE OF SERVICE:	MONTH	DAY	YEAR

SERVICE PROVIDED	NUMBER OF UNITS	X	COST PER UNIT	TOTAL CHARGES	PROVIDER NUMBER
INTAKE INTERVIEW (OUTPATIENT METHADONE)					
ADMISSIONS INTERVIEW (RESIDENTIAL DRUG FREE)					
INTAKE INTERVIEW (OUTPATIENT DRUG FREE)					
INTAKE PHYSICAL EXAMINATION					
REVIEW OF PHYSICAL EXAMINATION					
GROUP COUNSELING					
MORNING SESSION					
INDIVIDUAL COUNSELING					
CASE REVIEW BY SUPERVISOR AND COUNSELOR					
FAMILY COUNSELING					
CASE REVIEW BY ENTIRE STAFF					
CASE REVIEW BY PSYCHIATRIST					
URINALYSIS					
METHADONE DISPENSING					
OTHER DRUG DISPENSING					
VOCATIONAL REHABILITATION COUNSELING					
RELATIVES' COUNSELING					
OCCUPATIONAL THERAPY					
RECREATIONAL THERAPY					
COUNSELING BY PSYCHOLOGIST					
COUNSELING BY PSYCHIATRIST					
MEDICAL REVIEW					
COUNSELING FOR SUPPORT SERVICE					
REFERRAL TO SUPPORT SERVICE					
FOOD					
TRANSPORTATION					
TOTAL CHARGES					
DISCOUNT (WHERE APPLICABLE)					
NET DUE FROM PATIENT					

Figure 6.2

SECTION 7

FINANCIAL MANAGEMENT

DEVELOPMENT OF A FEE SCHEDULE

All providers of drug treatment services who wish to be reimbursed by a third party payer must have a fee schedule. This is a list of services provided by the project or agency and the price charged the client for each.

A typical fee schedule would include specific charges for each type of service provided (e.g., individual counseling, group therapy session, methadone administration), each type of medication used (e.g., methadone), and fees for special services such as lab tests.

A fee schedule is necessary to ensure that the provider receives compensation for the costs incurred in providing service and to provide the basis for standardization of client charges. Having a schedule also makes the provider more acceptable to third party payers. Most insurance companies and publicly financed health programs require a fee schedule before they will authorize benefits.

The technical aspects of developing a fee schedule are beyond the scope of this manual. A basic overview of the steps to be taken in developing a fee schedule will be given; the cost elements that should be considered will be highlighted.

The basic prerequisite for the development of a fee schedule is determination of costs; you can't know what to charge for a service until you know what it costs you to provide it.

Accounting System

In order to determine costs of services, it is necessary to have a reliable and accurate accounting system. Such a system should operate on the accrual basis. In the accrual basis of accounting, income is recorded at the time it is earned, rather than when it is received. Likewise, expenses are recorded at the time they are incurred, rather than when they are paid. Hence, the accrual basis allows for periodic evaluation of an organization's financial status. An organization reporting on the accrual basis would consider costs billed to Blue Cross-Blue Shield as income at the time of billing. It would record as expenses all bills when they arrive, irrespective of when those bills are paid. The "accounts receivable" and the "accounts payable" are developed from this basis. This system involves double entry bookkeeping and a competent person to operate it.

Of importance to agencies that must recognize the inability of some clients to pay for services is a write-off mechanism that is noted in the receivable accounts of accrual basis accounting. The write-off mechanism accounts for uncollectible billings.

The other basis for accounting is called the cash basis, and operates just about the same as your personal checkbook. If you have ever had to count on next week's paycheck, knowing that certain bills were waiting to be paid, you can see the merit of the accrual basis of accounting.

Expenses

Expense accounts, that is,costs of the project, can generally be divided into two categories: direct costs and indirect costs.

Indirect Costs

Conventionally, indirect costs cover administrative and supportive expenses. They include outside activities such as legal and consultant services to the project, rental of space and equipment, and salaries and benefits of administrative employees.

Direct Costs

In providing treatment for drug addiction, each separate encounter is likely to involve several different services. The expenses incurred in providing each of these services are called direct costs. An accounting system should allow for easy accumulation of direct costs. Each direct cost needs to be identified. Examples of direct costs are: staff time, pharmaceuticals and other supplies used, laboratory fees.

One means of identifying client staff costs is to have each staff member keep records identifying the type of service performed and the time devoted to it. These times would then be accumulated by service and costed by the salaries involved. You would then know how much it costs to provide each service, exclusive of administrative costs.

Administrative costs should be allocated to each service. One procedure for making this allocation is to assign administrative costs in direct proportion to the cost of the service as related to the costs of all services. For example, if counseling costs are 25 percent of all direct service costs in your program, the associated administrative costs would be 25 percent of all administrative costs.

It may or may not be program policy that all program costs be allocated to the fee schedule. A fund accounting system will be able to separate out those expense items that should not be charged to the client or that have a funded source of support.

Relatively simple accounting systems can be set up for a reasonable one-time charge by a local accounting firm; however, as a project grows large and more financial information is needed by both management and outside interested parties, the presence of a permanent fiscal officer is desirable.

Fund Accounting

Most nonprofit health service organizations employ fund accounting to separate monies over which outside forces have control from those that are entirely at the discretion of the Board of Directors. Grants that come from federal and state agencies are considered to be restricted funds, because the provider of the money has detailed the ways in which it may be spent. All monies not restricted are "general fund" monies. As a result of pressures from the National Health Council, fund accounting has become widely used in recent years.

Further information on handling of fund accounting may be obtained from the National Health Council Standards for Accounting prepared by the American Institute of Certified Public Accountants. The standards are available from the National Health Council, 1740 Broadway, New York, New York 10019. The United Fund agency in your area should be able to provide assistance in understanding and using fund accounting principles. Another useful resource is the book Accounting for Non-accountants.*

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*Myer, John N. Accounting for Non-accountants. New York: Hawthorn, 1968.

Determining Costs of Services

Once the expense accounting has been accomplished, it is necessary to further allocate expenses to the major functional components of the program. This further division is necessary to define cost categories that will serve as a workable basis for the build-up of a cost for a particular unit of service. Program costs can generally be divided into the categories: direct costs, ancillary costs, and indirect costs.*

- Direct Costs are those costs that are directly attributable to the provision of client-related services. Examples of such costs are staff costs, laboratory costs, consumable supplies, etc.
- Ancillary Costs are those costs incurred to support the drug treatment delivery system with services such as outreach, program evaluation, food services.
- Indirect Costs are those costs not directly related to the provision of services, but which support the management of the program.

In order to determine the cost of each service provided, it is necessary to determine the various direct, ancillary, and indirect cost elements in it, and then estimate the extent to which each cost element is involved (e.g., hours of staff time, cc's of methadone).

Direct Costs

The major element in direct costs is staff costs. Staff costs per unit of service (e.g., counseling session) can be calculated by determining the average amount of staff time per staff category (e.g., counselor, senior counselor, lab technician, etc.), per encounter and multiplying this figure by the average salary per staff category.

Example: The time spent in five counseling sessions conducted by three different counselors was recorded for program X. The times and counselor salaries (hourly) were as follows:

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*This material is based on information presented in the NIDA Financial Management Seminars.

TIME PER SESSION (minutes)	COUNSELOR SALARIES (hourly)
40	$6.15
30	6.50
35	6.60
45	6.50
35	6.60

In the above example, the average time per counseling session is 37 minutes and the average hourly salary for a counselor is $6.47. Thus, in this case, the estimated staff cost per counseling session is $3.95.

A similar procedure is used to estimate the amount of "other direct costs" (i.e., direct costs other than staff). For the purpose of our example, let us assume that a permanent taped record is made of each counseling session at a cost of $1.25 per tape. This, then, would be an "other direct cost." Adding this cost to the cost of the staff time would bring the total direct cost of each counseling session to $5.20.

Ancillary and Indirect Costs

Ancillary and indirect costs represent those costs that are not directly attributable to the provision of client-related services. Since such costs are incurred as the result of their role in the support of the entire program, they must ultimately be distributed to each of the services provided.

This distribution process allows each service to share in the absorption of the ancillary and indirect costs. However, some services must be provided to more clients than others, some require more space than others, and some cost more to deliver than other services. Consequently, those services that constitute a larger portion of the total services provided by a program should receive a larger distribution of the total ancillary and indirect costs.

The total of the ancillary and indirect costs must be determined and then allocated to the various services. The manner in which the ancillary and indirect costs are allocated to each type of service is based upon a logical relationship between all services and a variable, such as office space or other direct cost. A number of different variables may be used for this purpose.

The individual cost components of the total ancillary and indirect cost can also be allocated separately based upon different variables. For example, the indirect cost of office space could be allocated to each service based upon the square footage that each service uses, whereas the indirect cost of administrative materials could be allocated based upon the number of clients a particular service serves. Other ancillary and indirect costs might be allocated based upon other logical variables.

Ancillary and indirect costs can be allocated to each type of service according to the proportion of the total direct costs allocated to that service. If, for example, the direct counseling costs are 25 percent of all direct service costs, the associated ancillary and indirect costs could be estimated to be 25 percent of all such costs. Thus, if the annual total of all ancillary and indirect costs for the program are $35,000, then $8,750 would be allocated to counseling services. Assuming that the program provides a total of 3,000 counseling sessions per year, the ancillary and indirect costs per counseling session would be $2.92.

Thus, in our example, the total cost of a counseling session would be $8.12 (3.95 + 1.25 + 2.92).

Once determined, costs of services are sorted by categories of expenses: employee benefits, contracted services, administrative expenses, space rental, and consumables (supplies and depreciation of durable equipment). These categories are usually set on a functional basis. For example, the entire cost of having an employee (payment of fringe benefits, overhead, etc.) is considered a salary expense. Another example involves contracted services, which pertain to the operation of the program, and not to expenses incurred from referring clients to such services. These contracted services would fall into a category that might be called client services. New categories are established when expense areas do not "fit neatly" into existing categories. The object of expense categories is to limit the number of expense accounts and still have a functional description of expenses. Your accounting system should allow for specific identification of cost areas within any category, whenever that information is necessary.

Based upon agreements with various third party insurers, there may be some limited types and levels of services that will be billed on a limited cost basis. For example, a funding agency may be willing to pay treatment costs of a program exclusive of the general administrative costs.

Shorthand Costing Method

A simple approach to estimating the costs of service is to first list every service you perform for your clients. Then identify which staff members are involved in providing this service. Determine the amount of time (on the average) each staff member spends with a client. Next, identify what, if any, medication, materials and/or supplies are used and the amount of each. Finally, relate the staff time and materials used to the cost of each encounter, based on some type of unit measure (e.g., hour of time, cc of methadone, etc.). You would also be wise to include a percentage of your overhead and the depreciation of durable equipment in your calculations.

For example, in a methadone maintenance clinic, you could watch several clients as they come in for service. Observe the procedure carefully. The clients come in, go to a clerk and state their names. The clerk pulls the clients' records and has them fill out forms or answer questions. In all, the clerk spends an average of ten minutes with each client before sending him to a nurse. The nurse does a quick check of temperature and blood pressure, asks a few more questions, then hands the client a paper cup containing the methadone. She spends an average of five minutes with each individual. Additionally, clients may also see a counselor for 20 minutes.

Now look at the visit in this way:

Personnel	Hourly Salary	Per Client Cost
One nurse for 5 min.	$10.00	$ .80
One clerk for 10 min.	3.00	.50
One drug counselor for 20 min.	6.00	2.00
Supplies		
One paper cup		$ .05
Pharmacy		
Methadone		$1.00
	TOTAL	$4.35

Service Unit Costing

Another approach to cost determination is service unit costing. Service unit costing describes the process of incorporating the estimate of what it costs a program to deliver specific health care services with the estimate of the units (or encounters, visits, sessions, consultations, etc.) of service to be used by the program's clients. In other words, it's like dividing a pie (the total cost of operating a program) into the number of pieces that will feed a certain number of guests (the service units).

Basic to the calculation of service unit costs is the determination and accounting for the program expenses incurred in the delivery of services. Simply put, all the dollars spent to provide the various services to the clients such as physical examinations, ancillary testing, medication, etc., must be accumulated and allocated over the anticipated number of times each service will be given.

These two methods, shorthand costing method and service unit costing, are not thoroughly detailed nor are they exhaustive. Your accounting firm may devise a method that will be more appropriate for your operation. However, some type of computation must be used to arrive at a reasonable fee for every service you provide.

You also need to consider the cost to your program of those clients who don't pay or those for whom reimbursement is only partial. For example, your cost for each administration of methadone may be \$4.35, but Medicaid may only allow \$4.00 for this type of service. The \$.35 difference per client visit must be charged to grant-in-aid or some other income source.

Establishing a Fee Schedule

Once costs for each service have been determined, charges for these services can be set. Generally the charge to be made for a service will be the actual cost of providing the service plus an allowance for uncollectible costs. However, your program may be able to absorb unrecoverable costs through the use of grant monies. In this case, your fee will be a direct reflection of your cost.

Charges are generally made on either a "fee-for-service" or "unit-of-service" basis. In a fee-for-service approach, a charge is made for each functional activity performed (e.g., in a methadone maintenance program, individual charges would be made for counseling, urinalysis, and dispensing). In the service-unit method, a single charge is made that covers the various functional activities involved in performing a given type of service, generally based on a given time frame. Hospitals, for example, use the service-unit approach in their daily room rate, which covers such items as nursing services, residents, orderlies, housekeeping, meals, etc. If the methadone program used the service unit method, a single charge could be made that would cover all of the functional activities involved.

There are two basic methods you can use (or adapt) to charge for your services. These are a uniform charge structure and a sliding fee schedule. Under the uniform charge structure, all clients are charged the same fee. Under a sliding fee schedule, the charge for a service is based on the client's ability to pay (based on availability of third party coverage and/or personal financial resources). With the sliding fee schedule, the charge made will in many cases be less than the cost of providing the service. Sliding fee charges are generally graded from the actual cost of the service to zero. Where a uniform fee structure is used, all clients are charged the full cost of the service; however, this charge may have to be waived (written off) for those clients unable to afford that amount.

Application of the sliding fee scale has presented problems with some third party payers. Many Medicaid programs and some private insurers require that a provider of service apply a uniform charge structure for all services rendered. It is important that a program check out such regulations and abide accordingly. The use of the sliding scale for payment based on ability to pay has been largely confined to federally or state-funded programs.

It is imperative that a bill be written up for each client receiving services from a program. This is necessary for a sound accounting system as well as for cost finding that relates to cost determination.

Many third party payers require that a uniform charge be made for all services to all clients. This does not mean that the program is expected to collect all or even any of the costs from the client, but the accounting system must show that such a charge was made against some income source. For example, if you bill Medicaid $5.00 for the administration of methadone, your accounting system must show that a $5.00 charge was made against your grant-in-aid (or some other) account for the administration of methadone to a client who is unable to pay for the service and is not eligible for any third party reimbursement. In some cases, the charge for a service might be accounted for by allocating the cost to two or more income sources.

Example:

Total cost of service		$35
Title XX	$15	
Client fee	15	
Grant-in-aid	5	

It is a sound practice to issue bills, even if the philosophy of your center has been to provide help whether the client is able to pay or not, because most insurance plans and publicly financed third party payers will not pay for care that is available free of charge. Some clients may well be able to pay for your service. For indigent clients, bills may be issued and then waived.

There are five basic methods of reimbursement:

- Direct cash payment
- Benefit waiver
- Direct reimbursement to client
- Reimbursement after discount/deductible
- Periodic interim payment

In direct cash payment, the client personally pays for services received.

In the benefit waiver (or assignment) form of payment, the client signs a legal release to waive his legal rights to benefits and to direct the insurance company to pay all money directly to the provider. The insured is bypassed completely once the assignment is received; the provider sends bills to the third parties and receives payments directly from them.

In direct reimbursement to client, the insured gets the money from his insurance company and then pays the provider. The provider normally still sends the claim to the insurance company and bills the client for charges that are not covered by the third party.

Reimbursement after discount/deductible means that the provider is reimbursed by the third party for the charges made, less the amount of the deductible specified in the policy. The provider must collect the deductible portion from the client.

In the periodic interim payment, the third party makes periodic payments for services related to a single illness or injury over the course of treatment. Here, payments are made on an ongoing basis to cover continued treatment or services rather than a single lump sum at the completion of treatment. This method is normally used only in cases of long-term treatment.

Basic Issues and Questions

There are several key questions concerning billing systems:

Who was the client? It is important that the billing personnel have reasonable knowledge of the characteristics of the client so that both specific (individual) and general (population) information about third party reimbursements may be ascertained. For example, if a majority of the clients are Medicaid enrollees, then it is helpful if the billing and collection office maintains a close relationship with the state Medicaid office.

What services were provided? An effective service-data collection system will account for all services rendered in a program no matter what the service may be. It is important that the billing system reflect the frequency of services regardless of the billing policy.

Who provided the service? The specific provider may be an issue in some jurisdictions because of state laws regarding licensure and registration of providers of health services. Through the billing system, you should be able to validate for third parties the credentials of particular individuals providing services. Usually, the names and credentials of professional providers affiliated with a program must be submitted to the third parties before bills will be processed by that third party.

What is the charge for services rendered? The program's fiscal officer will be responsible for supplying the billing office with the appropriate fee schedule for application of charges.

Is there co-insurance or deductible? The billing office must keep abreast of the status of certain plans of coverage with various third parties. Failure to collect a deductible or a co-insurance amount from the client while he is on-site may result in lost revenue to the program. All information regularly received from participating third parties should be maintained in an easily accessible place for reference on questions of deductibles and co-insurance.

Is any special billing information or form required? The billing office should request from each participating third party a supply of any and all forms necessary to properly bill for services provided to covered clients. In some instances, special forms may be requested from the program, the client, or both. The American Medical Association has developed a uniform claim form that many private insurors have adopted or modified to meet their specific needs. (Figure 7.1)

Billing Procedure Guidelines

There are certain qualities to be expected of a good billing system:

Accuracy -- There is little excuse for errors in charges or balance due.

Timeliness -- There should not be an excessive delay between the time services are provided and the date of billing.

Information -- The bill should be as explicit as possible about the encounter, indicating date of service, description of service, to whom the bill is addressed, and any other pertinent information.

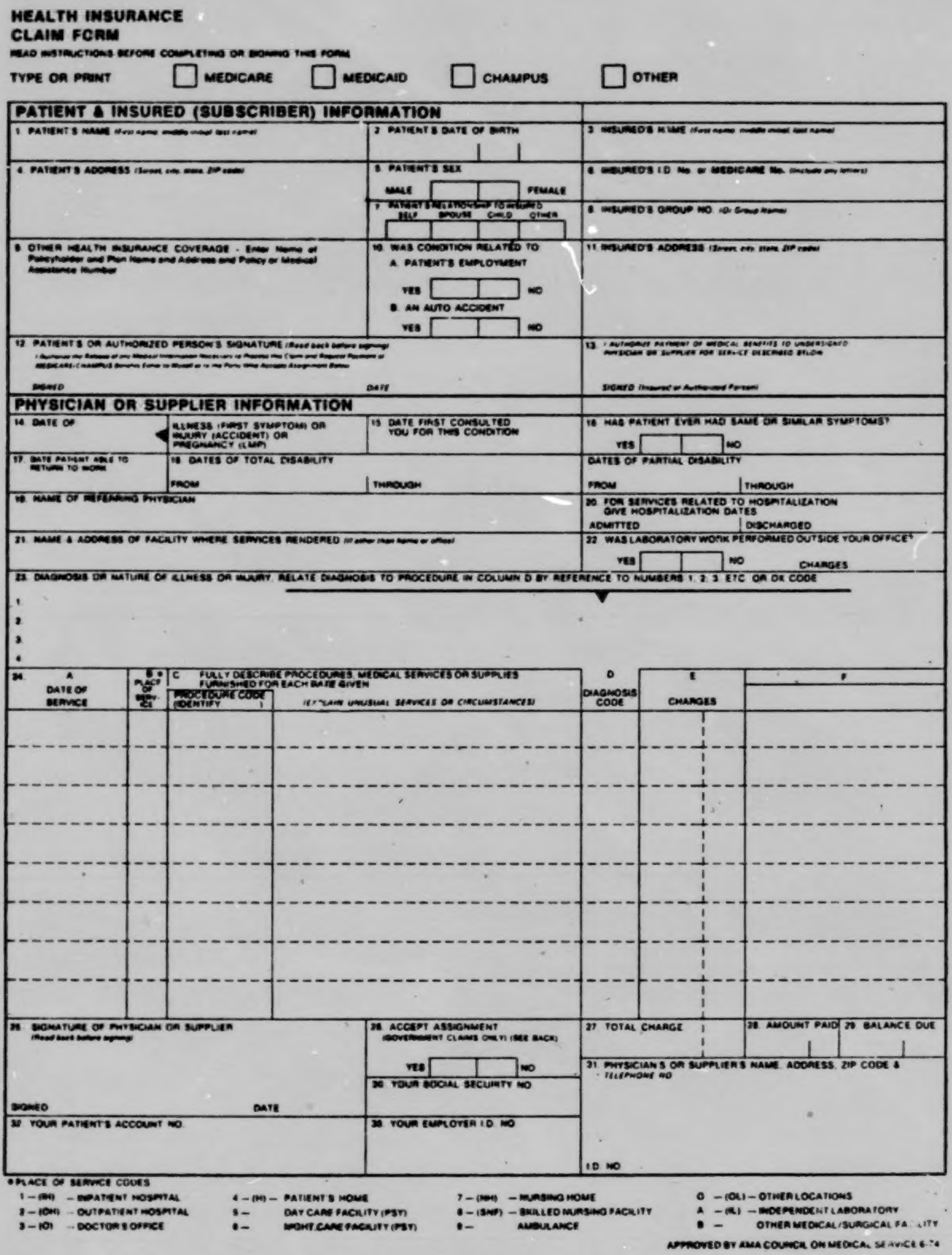
Format -- The physical appearance of the bill is important. It should represent a businesslike approach and be printed in language that the client will understand.

Terminology -- All terms used must be understood by and acceptable to third party payers.

Bill Preparation Process

A bill should be clear and concise and contain all of the information that will be needed by the client and his insurance company. Figure 7.2 is an example of a complete bill.

Item 1 on this bill is the name, address, and telephone number of the program. Item 2 is the inside address, which contains the name and address of the party responsible for the bill. This is not necessarily the person for whom services were performed. In the case of a minor, a parent or legal guardian would be responsible. Item 3 is the date the bill was prepared. The client's name (item 4) may be different from the name of the responsible party and will clarify matters if more than one family member is undergoing treatment. Item 5 is a list of the services rendered



HEALTH INSURANCE
CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

TYPE OR PRINT ☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ OTHER

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (First name, middle initial, last name)
2. PATIENT'S DATE OF BIRTH
3. INSURED'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)
5. PATIENT'S SEX MALE ☐ ☐ FEMALE
6. INSURED'S I.D. No. or MEDICARE No. (Include any letters)
7. PATIENT'S RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐
8. INSURED'S GROUP NO. (Or Group Name)
9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number
10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES ☐ ☐ NO B. AN AUTO ACCIDENT YES ☐ ☐ NO
11. INSURED'S ADDRESS (Street, city, state, ZIP code)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing)
SIGNED DATE
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
SIGNED (Insured or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ◀ ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ ☐ NO
17. DATE PATIENT ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
19. NAME OF REFERRING PHYSICIAN
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ ☐ NO CHARGES
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE
1.
2.
3.
4.

24. A DATE OF SERVICE	B * PLACE OF SERV-ICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F

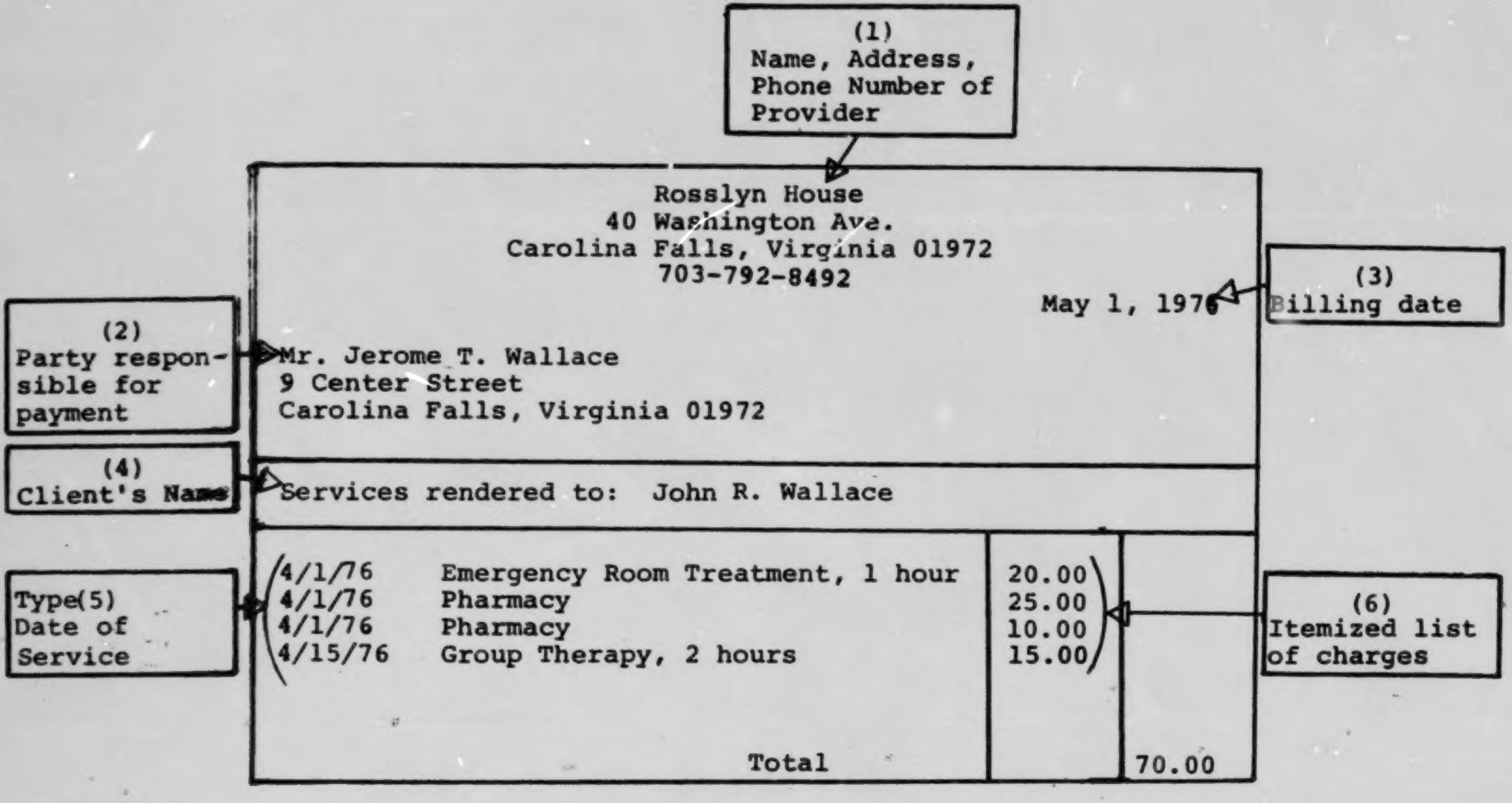
25. SIGNATURE OF PHYSICIAN OR SUPPLIER (Read back before signing)
SIGNED DATE
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES ☐ ☐ NO
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. YOUR SOCIAL SECURITY NO.
31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.
I.D. NO.
32. YOUR PATIENT'S ACCOUNT NO.
33. YOUR EMPLOYER I.D. NO.

*PLACE OF SERVICE CODES

1 — (IH) — INPATIENT HOSPITAL	4 — (H) — PATIENT'S HOME	7 — (NH) — NURSING HOME	O — (OL) — OTHER LOCATIONS
2 — (OH) — OUTPATIENT HOSPITAL	5 — DAY CARE FACILITY (PSY)	8 — (SNF) — SKILLED NURSING FACILITY	A — (IL) — INDEPENDENT LABORATORY
3 — (O) — DOCTOR'S OFFICE	6 — NIGHT CARE FACILITY (PSY)	9 — AMBULANCE	B — OTHER MEDICAL/SURGICAL FACILITY

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6-74

Figure 7.1 Uniform Claim Form developed by the American Medical Association


(1) Name, Address, Phone Number of Provider
(2) Party responsible for payment
(3) Billing date
(4) Client's Name
Type(5) Date of Service
(6) Itemized list of charges

Rosslyn House
40 Washington Ave.
Carolina Falls, Virginia 01972
703-792-8492

May 1, 1976

Mr. Jerome T. Wallace
9 Center Street
Carolina Falls, Virginia 01972

Services rendered to: John R. Wallace

4/1/76	Emergency Room Treatment, 1 hour	20.00	
4/1/76	Pharmacy	25.00	
4/1/76	Pharmacy	10.00	
4/15/76	Group Therapy, 2 hours	15.00	
	Total		70.00

Figure 7.2 Sample Bill for Services

Jerome Wallace
9 Center Street
Carolina Falls, Virginia 01972

Client: John Wallace

		Charges	Balance
4/1/76	Initial Evaluation	20.00	
4/1/76	Physical Examination	25.00	
4/1/76	Urinalysis	10.00	
4/15/76	Group Therapy, 2 hours	15.00	
			70.00
5/1/76	Billed Federated Mutual		
7/1/76	Payment: Federated Mutual	50.00	20.00
7/15/76	Billed client	20.00	20.00
8/1/76	Payment: Client	10.00	10.00

Figure 7.3 Sample Master Ledger Sheet

and the dates on which they were given. Item 6 is the charge made for each of the services provided.

You can facilitate bill preparation with a master ledger sheet showing, for each client, amounts owed, amounts paid, date and amount of claims sent to third parties, and results of claims (see Figure 7.3). Standard forms are available for this purpose and are designed to be photocopied to save typing a bill.

Some Billing Caveats

Classify Services by Categories; Use Acceptable Terminology

When dealing with third party payers, you should communicate with them in language that they understand. It is doubtful, for example, that a diagnosis of a "bad trip" would be considered appropriate. Administration of methadone, naloxone, or other blocking drugs can be billed as pharmacy charges or drug therapy. The care of resident clients can be classed under room charges. Detoxification or care of overdose victims, if you are equipped for this, is emergency service. Rap sessions might be covered as group therapy under those policies providing for psychiatric care.

Remember that every discipline, whether journalism or aerospace engineering, has its own nomenclature and that the jargon used in one field is completely foreign to those who work in another. The terminology of data processing is incomprehensible to a dietician, and the street talk of the drug world is probably equal gibberish to an insurance clerk.

The issue of terminology is also important when dealing with any of the governmental third party payers. Not only is the claim procedure sometimes more rigid, but the acceptable terms may be more limited.

There are books available that can help you in the use of proper terminology, for example: Paramedical Dictionary by J. E. Schmidt, M.D.; Understanding Medical Terminology by Sister Mary Agnes Clare Frenay, S.S.M. (the fifth edition has a section on drug addiction); and Uniform Hospital Definitions by the American Hospital Association, which deals with units and measurements and is partially aimed at third party payers.

Separate Covered Elements from Uncovered Ones

Even the most liberal insurance plan will not cover all of the services you may provide in your center. For instance, job placement, vocational rehabilitation, or outreach programs may

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not be billed to insurance companies or other third party payers. Similarly, a counseling session might be covered if conducted in the center, but not if it takes place in the streets or over the phone.

To keep operations legitimate in the eyes of third parties, to protect yourself during auditing, and to formalize your own accounting procedures, you must keep charges that are covered (room charges, pharmacy, etc.) separate from those that are not. For example, a two-hour session that is partially group therapy but mostly vocational rehabilitation must be broken down clearly into segments, as one may be covered treatment and the other not. The best procedure would be to break the session into two distinct parts, one devoted to each of the above services. Staff time should be broken down in a similar fashion. If one staff member conducts group therapy sessions several times a day, with the rest of his time spent on the streets doing outreach, his time should be separated into two accounts.

It is often very difficult to know which program elements will be covered and which will not. Conventional establishments such as hospitals learn through experience what is likely to be covered. For example, the room charge includes the cleanup, the linens, use of water glasses, etc. These items are not accounted for or billed separately by the hospital, simply because experience has shown that they are all covered charges if the room itself is covered.

Drug abuse treatment centers have much less experience to go on as to what will be covered, making billing separations more important than in the usual hospital situation. You might even want to separate the methadone itself (pharmacy charges) from the services and disposable supplies. You certainly would want to separate group therapy from vocational rehabilitation counseling. Experience will determine the exact degree of separation that is helpful and necessary. If you start out separating elements, you can always combine them later if you find it an unnecessary task. If you start out combining components, you'll probably have a tough time separating them at a later date.

COLLECTION PROCEDURES

There should be written policies regarding the entire collection process including strategies for collecting outstanding indebtedness and dealing directly with paying clients. This is particularly important due to the "cash flow" problem inherent in a third party payments system. That is, services are provided and costs are incurred in providing these services (staff salaries, supplies, rent, etc.) before payment is received. This situation is in direct contrast to the grant system, in which monies are received prior to providing services.

Collection Policy

There should be a written collection policy that will address the following basic issues:

- When an account should be followed up
- How the follow-up will be accomplished
- Who should do the follow-up
- Who decides that an account is uncollectible

Follow-up

A copy should be kept of all claims submitted to third party payers. Follow-up on these claims may be necessary due to delays in receiving reimbursement. Payment of a claim may be delayed for a reason as simple as a mistyped policy number or a misspelled policyholder's name, or as serious as a question about the eligibility of the service itself or your program's legitimacy.

All follow-up should be conducted by letter in order both to formalize the inquiry and to provide a record of the action taken. Your letter should include all pertinent information to help the third party locate your claim. The most important items to include are: (1) the claim number (from the claim form), (2) the policy and/or group number, (3) the date on which you sent the claim, (4) the name of the insured party (not necessarily the client), (5) the person served, (6) his status--inpatient or outpatient--(there may be different departments to handle each type of claim), and (7) the dates services were given.

Collection procedures are a necessary part of a third party payment system that can and should function in a nonthreatening manner and serve as the final step in the system.

APPENDIX A

GLOSSARY

GLOSSARY

ACCESSIBILITY	Those qualities of a facility or service that affect an individual's ability to make use of that facility or service. These qualities relate to, but are not limited to, capacity, location, eligibility requirements, costs, and visibility.
ACCREDITATION	The process by which an agency or organization evaluates and recognizes a program of study or an institution as meeting certain predetermined qualifications or standards.
ADMINISTRATION	Refers to the general management and business aspects of a program as opposed to direct client services.
ADMISSION	The point of completion of the intake process at which time the client may receive the full services of the program.
AFDC	Aid to Families with Dependent Children. Title IV, Part A of the Social Security Act, as amended. Federal payments to states to aid them in furnishing financial assistance to low income families with children.
AGENT	An individual or firm authorized by an insurance company to sell policies and collect premiums.
AMBULATORY CARE	Health services rendered to persons who are not confined overnight in a health care institution. Ambulatory care is often referred to as "outpatient services."
ANCILLARY CHARGE	A fee for service rendered upon request of the primary provider by an auxiliary service unit (e.g., laboratory) and not included in the basic charge made by the individual provider.
APPLICANT	An individual seeking admission to a program. Upon admission to the program, an applicant becomes a client (or patient).

ASSESSMENT AND REFERRAL PROGRAM	As defined by the Joint Commission on Accreditation of Hospitals: a program with a staff, budget, facilities, and other resources that functions under a defined set of policies and procedures related to assessing the needs of drug abusing individuals and referring such individuals to appropriate treatment resources. An assessment and referral program is often, though not necessarily, operated for the purpose of doing intake processing for several independent drug abuse programs or for an agency operating several programs.
ASSIGNMENT (or ASSIGNMENT OF BENEFITS)	A procedure by which the client assigns his right to reimbursement from a payer to the provider. The provider then collects directly from the third party.
BENEFICIARY	The person or persons identified in an insurance contract to receive all or part of the benefits.
BENEFITS	The specific types of services and/or treatment that will be reimbursed by a third party payer.
BENEFIT PERIOD	The time period during which a third party will pay for services related to the treatment of a condition or illness.
BENEFIT SCHEDULE	A list of benefits to be paid to the insured under his policy. For example, a surgical benefit schedule would list maximum benefits for a variety of specific surgical procedures.
BENEFIT STRUCTURE	A description of the services for which a third party payer will provide reimbursement when the services are rendered to individuals who are eligible for coverage under the payer's plan by eligible providers. Usually this description is in the form of a list of specific reimbursable services; occasionally it may be in the form of the statement that all services of a general type (e.g., physicians' services) are covered except certain specified exclusions.
BINDER	Temporary insurance pending execution of the policy contract.

BUREAU OF HEALTH INSURANCE (BHI)	A bureau of the Social Security Administration that is responsible for administration of the Medicare program.
BUY-IN	An option granted to states to enable them to use federal Medicaid funds to buy Medicare Part B coverage (outpatient) for Medicaid recipients eligible for Medicare coverage as well. When this occurs, the Medicaid obligation is limited to the deductible and coinsurance amounts for services covered under Medicare.
CAPITATION	A method of charging for health care services whereby an individual or family unit receives all needed services in return for a single fee, which is generally assessed on an annual basis in advance of receiving services. This is in contrast to "fee-for-services," whereby a separate charge is made for each service provided.
CARRIER	The technical designation for an insurance company because it carries the risk of paying for needed services.
CASH FLOW	The stream of cash receipts and disbursements generated in the course of program operations. The combined effect of these streams represents the net cash status of the program.
CASPP	See Comprehensive Annual Services Program Plan.
CATEGORICALLY NEEDY	The descriptive designation of one of two classes of medicaid-eligible persons (see also Medically Needy). Categorically needy individuals receive Medicaid benefits because they are eligible for welfare benefits defined categorically for the blind, the disabled, the aged, and families of dependent children. All states participating in Medicaid must cover required services for the categorically needy.
CERTIFICATION	The process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.

CHAMPUS	Civilian Health and Medical Program for the Uniformed Services, a public insurance program that pays for medical services provided by civilian practitioners to military dependents and retired military personnel.
CHRONIC ILLNESS	A prolonged or lingering illness usually not approaching a critical condition.
CLAIM	A demand that an insurance company pay for a benefit covered by an insurance policy.
COINSURANCE	A common form of insurance coverage in which the insured is required to pay some portion of the cost of the services received. This may be in the form of a "deductible" (q.v.), or a percentage coverage, whereby the insurance company pays a given proportion of the charges and the insured is responsible for the remaining portion.
COMMISSION	The fee paid to the insurance agent who sells the insured a policy. It is paid by the company out of the premium and is usually a percentage of that premium.
COMPREHENSIVE ANNUAL SERVICES PROGRAM PLAN (CASPP)	The annual state plan for title XX services. The CASPP identifies the type of services to be provided, types and numbers of clients to be served, and the costs of title XX services in the state.
COMPREHENSIVE REHABILITATION PROGRAM	As defined by the Joint Commission on Accreditation of Hospitals: a program with a staff, budget, facilities, and other resources that functions under a defined set of policies and procedures designed to achieve permanent changes in an individual's drug taking behavior and to ameliorate those problems resulting from his or her drug use. A comprehensive rehabilitation program provides the following client services: activities, legal assistance, mental health, physical health, social and vocational rehabilitation.
CONDITIONS	Provisions in an insurance policy pertaining to the promises of the insurer, the obligations of the insured, the rights of both parties, and the limitations or exclusions of the policy.

CONFIDENTIALITY	The process of safeguarding client information to prevent unauthorized disclosure.
CONTRACT YEAR	The 365-day period during which an insurance policy is in effect.
CONTRIBUTORY PLAN	A form of group insurance where covered persons pay a portion of the premium usually through payroll deduction. (See Noncontributory Plan.)
CONVERSION	The process of changing from one type of insurance policy to another. For example, a change from a group to a private policy after retirement.
CONVERSION PRIVILEGE	A clause in an insurance policy giving the insured the right to change to a different type of policy.
CONVERSION RIGHTS	See Conversion Privilege.
CONVERTED CONTRACT	A policy issued after a conversion privilege is exercised.
COVERED SERVICES	Those services provided by a health care delivery organization that are reimbursable by one or more third party payers. A program may have more than one set of covered services as payers differ with respect to the specific services they will pay for.
CREDENTIALING	A generic term encompassing accreditation, certification, and licensing.
DEDUCTIBLE	A specified dollar amount, which an individual is expected to pay personally toward the cost of his health care services during a designated time period before being eligible to receive reimbursement from a third party source.
DIRECT CLIENT PAYMENTS	Any form of client self-payment for services rendered. Direct client payments may be either for the full cost of services rendered or for some predetermined portion of those costs.
DIRECT COSTS	Expenses that are directly related to the provision of services (e.g., staff salaries, pharmaceuticals, laboratory fees).

ELIGIBLE CLIENT	A client who qualifies for benefits from a third party.
EMERGENCY PROGRAM	As defined by the Joint Commission on Accreditation of Hospitals: a program with a staff, budget, facilities, and other resources that functions under a defined set of policies and procedures designed for the treatment of acute, severely debilitating and/or life-threatening conditions.
ENCOUNTER	A face-to-face contact between a client and a program staff member providing some form of treatment or rehabilitative service.
ENCOUNTER FORM	A form on which medical and billing information regarding an encounter is entered by the individual providing the services.
EPSDT	Early Periodic Screening, Diagnosis, and Treatment (of conditions found)--a program required to be included and covered in state Medicaid plans in which screening, diagnostic, and treatment services are provided to all Medicaid-eligible persons under the age of 21.
EXPENDITURE	A cost incurred either through the commitment of credit or the disbursement of cash.
FEE-FOR-SERVICE	A method of charging for health care services whereby a specific charge is assessed for each service provided.
FEE SCHEDULE	1) A list of services that may be obtained from a provider together with the charge normally made for each. 2) A payer's list of acceptable fees, established allowances, or maximum reimbursement for covered services.
FISCAL AGENT	An organization that is responsible for processing medical claims submitted to a third party payer. The responsibility of a particular fiscal agent is normally limited to a given geographic area (e.g., region, state, or county).
FIXED COSTS	Costs incurred regardless of whether resources are consumed. These costs (such as rent expense, maintenance, heating) do not vary with utilization.

FOLLOW-UP	Actions related to obtaining payment for an outstanding bill.
FREESTANDING CLINIC	A facility providing only outpatient services that is physically, administratively, and financially independent of any controlling organization.
GROUP INSURANCE	Insurance coverage for an identifiable group of people, usually employees of one firm or members of an association or organization.
HEALTH CARE PROVIDER	See Provider.
HEALTH MAINTENANCE ORGANIZATION (HMO)	A prepaid, capitation-based health care system providing a comprehensive set of services to a voluntary, enrolled population.
INDEMNITY POLICY	A form of insurance whereby the insured is reimbursed for the actual cost of medical services up to the dollar limit of the policy, less any deductible.
INDIRECT COST	Expenses that are not directly related to the provision of services (e.g., program administration, rent, utilities).
INDIVIDUAL PROVIDER	A physician or other health care worker who provides treatment or services to clients. An individual provider may operate independently or as a staff member of a program.
INPATIENT	A person receiving medical care who has been formally admitted to a hospital.
INSTITUTIONAL PROVIDER	An agency or organization providing health care services.
INTERMEDIARY	The fiscal agent authorized by Medicare to administer reimbursement for Medicare Part A. Under certain, specified conditions, an intermediary may also perform the functions of a carrier in making Part B reimbursements.
JCAH	Joint Commission on Accreditation of Hospitals. A private organization sponsored by the American College of Physicians, the American College of Surgeons, the American Hospital Association, and the American Medical Association, which operates to accredit various types of medical facilities.

LICENSURE	The process by which an agency of government grants permission to persons meeting certain qualifications to engage in a given occupation, or through which the agency grants permission to institutions to perform specified functions.
LIMITATION	The maximum amount a policy will pay for a given accident or illness. The specified maximum may apply to a particular category of care (e.g., inpatient services), a specific incident, or a particular illness, or a given procedure (e.g., detoxification).
LIMITED SICKNESS POLICIES	Insurance policies that cover only a specific disease such as cancer. Also called "dread disease contracts" or the "polio disease indemnity" because of their original purpose.
MAJOR MEDICAL	A type of supplementary health care insurance coverage that reimburses the insured for some set percentage of the charges incurred after a specified amount of money has been paid out by the regular policy for a single accident or illness.
MAXIMUM BENEFIT	The highest amount that a third party will pay for a particular category of care, or type of service, incident, illness, or procedure.
MEDICAID	A federal-state program under which the categorically and medically needy are assisted in paying their costs of health care. The federal legislation authorizes federal grants to states to cover varying shares of the costs of designated medical services provided. The program is officially known as title XIX (of the Social Security Act)--Grants to States for Medical Assistance Programs.
MEDICAL SERVICES ADMINISTRATION (MSA)	The federal agency responsible for administering the Medicaid program in the Social and Rehabilitation Service of the Department of Health, Education and Welfare.
MEDICALLY NEEDY	One of the two general classes of Medicaid eligibles. The medically needy are individuals whose income and/or financial resources are presumed to be adequate to enable them to pay routine living costs but insufficient to cover health care services. This coverage is optional for the states.

MEDICARE	A federally sponsored hospital insurance program for the aged and disabled and supplementary medical insurance benefits for ambulatory care. Two types of coverage are available: Medicare Part A deals with inpatient care, Part B (Supplementary Medical Insurance) with outpatient care. Part A is automatic in that everyone eligible is included. Part B coverage is provided only when the patient enrolls and pays a monthly premium. The program is officially known as title XVIII (of the Social Security Act)--Health Insurance for the Aged and Disabled.
NONCONTRIBUTORY PLAN	A group insurance plan where the employer pays the entire premium for the employees.
OUTPATIENT	A person receiving medical care from a hospital or clinic while residing at home. (See also Ambulatory Care.)
PARTIAL PAY CLIENT	A client who is billed less than the normal charge for a service because his financial resources are limited (see Sliding Fee Schedule).
PARTICIPATING PHYSICIAN	A physician willing to process claims to, and accept payment from, Medicare, Medicaid, and private insurance companies.
PATIENT	See Client.
PRE-EXISTING CONDITION	An injury or illness that existed before a given insurance coverage became effective.
PREMIUM	The charge made by a carrier for an insurance contract. The charge is generally set on an annual basis.
PREPAID GROUP PRACTICE	An organization composed of physicians and other health care professionals who contract to provide a wide range of preventive, diagnostic, and treatment services on a capitation basis for enrolled participants.
PREPAYMENT	See Capitation.
PROFESSIONAL STANDARDS REVIEW ORGANIZATION (PSRO)	An organizational entity established for the purpose of assessing the need for and appropriateness of the length of stay and quality of inpatient treatment provided by facilities

	receiving reimbursement under Medicare, Medicaid, and the Maternal and Child Health Service Programs.
PROVIDER	A physician, hospital, or other treatment facility that furnishes health care services to a client.
PROVIDER STATUS	Denotes formal recognition of a health care provider, by a third party, as eligible to collect reimbursement for services rendered.
PROVISIONAL RATE	A tentative premium subject to a refund or additional payment as indicated by experience with the risk. Also known as retrospective or tentative rating.
PSRO	See Professional Standards Review Organization.
PURCHASE OF SERVICES AGREEMENT	The formal, written contract between a title XX agency and a provider.
RECORDS	All oral communications and written materials related to the identification, registration, diagnosis, prognosis, treatment, or any other form of assistance provided to past and current clients.
REINSTATEMENT	The renewal of an insurance policy following its cancellation due to nonpayment of premiums. This renewal is accomplished by payment of the required premium and submission of evidence of insurability to the carrier.
RELATIVE VALUE SCALE	A method of determining fees for services; the most common services are listed and a unit value, based on the cost elements involved (e.g., staff requirements, time involved, supplies and materials used) is assigned to each. In one such scale, for example, a simple injection is rated as 8 units, an initial comprehensive history and physical examination of an adult is rated at 70 units, and a cardiac catheterization procedure is rated at 300 units. These units are frequently converted to dollar fees by multiplying by a constant "conversion factor." In the above example, application of a $1.25 conversion factor would result in fees of $10, $87.50, and $375, respectively, for the three services.

RELEASE FORM	A legal document whereby a client grants permission to an individual or organization to make information regarding his condition and/or treatment available to another individual or organization.
RIDER	An agreement not contained in the basic policy contract that may be attached to the policy to extend or restrict coverage to fit individual circumstances. Also called an endorsement.
SELF-PAY	A bill for services that is the total responsibility of the client.
SERVICE UNIT	A measure of the activity or production of a particular segment of an organization. For example, a laboratory's service units are the number of tests performed and a pharmacy's service units are the number of prescriptions filled.
SHORT-TERM DETOXIFICATION PROGRAM	As defined by the Joint Commission on Accreditation of Hospitals: a program with a staff, budget, facilities, and other resources that functions under a defined set of policies and procedures. Its purpose is to effect the systematic reduction in an individual's physical dependence on drugs; such reduction is usually accomplished within 21 days.
SLIDING FEE SCHEDULE	A fee schedule under which the fee charged the client for services varies with his ability to pay. When this type of fee schedule is used, clients who are not covered by a third party source are classified as "full pay" (pay 100% of the charges), "partial pay" (pay between 1% and 99% of the charges), and "no pay" (program bears the entire cost of services and receives no reimbursement).
SMI	Supplementary Medical Insurance. (See Medicare Part B.)
SSI	Supplemental Security Income for the Aged, Blind, and Disabled. Title XVI of the Social Security Act, as amended. Federal payments to states to aid them in furnishing financial assistance, medical, and rehabilitative services to individuals who are 65 years of age or older, blind, or permanently and totally disabled.

STATISTICAL VISIT CHARGE	A flat charge for each client encounter irrespective of the type of service rendered. The given charge is generally developed by determining an average cost-per-encounter and using this figure as the rate charged for every type of encounter.
SUBSCRIBER	The person or organization that obtains insurance coverage. Same as "insured."
SUPPLEMENTAL SECURITY INCOME (SSI)	A 100% federally funded program providing monthly cash payments to the aged, blind, and disabled, as authorized under title XVI of the Social Security Act.
THIRD PARTY PAYER	An organization or individual other than the person receiving treatment or rehabilitative services that pays for all or part of such services.
THIRD PARTY PAYMENTS/ REIMBURSEMENTS	Payment (for service received by an individual) by an organization, agency, or individual who is neither the receiver nor provider of the service.
TITLE XIX	See Medicaid.
TITLE XX	A federal/state sponsored program to provide support for nonmedical, social welfare services to low income individuals and their families. The program is officially known as title XX (of the Social Security Act)--Grants to States for Services.
TOKEN PAYMENT	A partial payment made for a service or supply item. For example, some comprehensive prepaid health plans charge $1 for each office visit. Sometimes also known as "nominal" or "hesitation" payments.
UNDERWRITER	See Carrier.
VALUED BASIS POLICY	A form of insurance whereby the insured is paid a fixed dollar amount for each day during which he is hospitalized, up to a specified maximum number of days. The amount paid to the insured is related solely to the number of days he is hospitalized and not to the costs actually incurred, as is the case in an "indemnity policy."

VENDOR NUMBER	An identification number assigned to a provider by a third party payer that confirms the provider's eligibility to be reimbursed for covered services provided to eligible clients.
VOCATIONAL REHABILITATION	The process in which a disabled individual is assisted by one or more specialists in getting the training, education, and counseling needed to make the physical and/or social adjustments necessary to become employable.
WAITING PERIOD	A length of time, specified by a third party, from the beginning of an illness before benefits are payable. For example, under some medical insurance policies, the insured is eligible for benefits only after the seventh day of an illness.

APPENDIX B

STATE MEDICAID CHARTS

STATE MEDICAID CHARTS

This appendix provides state-specific information relating to client, provider, and service eligibility criteria for title XX (social services funding). Additionally, the name, address, and telephone number of the appropriate state authority and an individual to be contacted for further information are listed.

This information was obtained in March 1976 through direct contacts with the various state authorities and verified for accuracy at that time. However, as state title XX plans are revised annually or at other specified periods, specific items should be checked prior to initiating actions solely on the basis of this material. Additionally, the voluminous nature of each state's Comprehensive Annual Services Program Plan has necessitated a highly abbreviated. and therefore incomplete, presentation.

This information is intended to help you make a preliminary determination of the potential relevance of your state's title XX program as a third party payer. To do this, you should relate the accompanying information to the characteristics of your program and its client population. If it appears worthwhile to pursue title XX as a reimburser, you should contact the state authority to obtain more specific information regarding coverage, eligibility, and the procedure for initiating a Purchase of Services Agreement.

STATE Alabama

Responsible State Agency: Board of Health (Administering Unit: Medical Services Administration)

2500 Fairlane Drive, Montgomery, Alabama 36130 (205) 277-2170 Ext. 200
Address **Phone**

Suggested Personal Contact: Robert H. Holzworth, M.D., Director

A. Client Eligibility: Categorically Needy

Certified by: County Departments of Pensions and Security and Social Security Administration

B. Provider Eligibility: Providers certified by Medical Services Administration. Billing form serves as agreement between individual practitioners and the state.

Services Covered:

Physician: Provided. Service for chronic illness limited to one visit per month.

Psychiatrist: Provided

Psychologist: Not provided

C. Facility Eligibility: Provider agreement required between all facilities and the state.

Services Covered:

Hospital: Provided. Limited to 20 days per calendar year. Extensions must have prior approval. Extensions limited to 10 days for patients over 21, unlimited for those under 21.

Clinic: Not provided.

Methadone: There is only one methadone program in the State of Alabama. There is a special arrangement with it to pay for services.

D. Payment Information: Processed and paid by Blue Cross Blue Shield of Alabama with sub-contract to Central Computer Services of Birmingham, Alabama.

E. Remarks: Only one drug abuse program has applied for provider status. There are no provisions for drug abuse detoxification or rehabilitation in the state plan, unless treatment is provided in a general hospital. Any future agreements between Medicaid and drug abuse treatment programs can only be arrived at through special arrangements.

STATE Alaska

Responsible State Agency: Department of Health and Social Services, Division of Public Assistance

Pouch H07 Juneau, Alaska 99811 (907) 465-3355
Address **Phone**

Suggested Personal Contact: Dr. Alistair Chalmers

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: District Offices of Division of Public Assistance

B. Provider Eligibility: State Division of Public Assistance certifies all providers. Provider agreement required between the state and all providers.

Services Covered:

Physician: Provided

Psychiatrist: Provided

Psychologist: Provided. Must be employed by a physician.

C. Facility Eligibility: Facilities must have valid licenses and possess provider agreement with the state.

Services Covered:

Hospital: Provided

Clinic: Not provided

Methadone: Provided. Must be prescribed by individual physician. No methadone clinics exist.

D. Payment Information: Administrative Services Division of Department of Health and Social Services processes claims. Payment made through Department of Administration.

E. Remarks: The Alaska State Medicaid Program is strictly limited by the state legislature to minimum services. Any services not included by the legislature are therefore excluded. Thus the only method by which a drug abuse treatment program could gain provider status would be through specific programmatic changes by the legislative body.

STATE Arizona

Responsible State Agency: Department of Health Services; Medical Assistance Division

1740 West Adams, Phoenix, Arizona 85007 (602) 271-3387
Address **Phone**

Suggested Personal Contact: Ms. Mary Potash

A. Client Eligibility: Categorically Needy

Certified by: County Department of Economic Security

B. Provider Eligibility: State Department of Health Services certifies providers. Provider agreement required between the state and all providers.

Services Covered:

Physician: Provided

Psychiatrist: Provided. Requires prior authorization after first two psychiatric visits.

Psychologist: Not provided

C. Facility Eligibility:

Services Covered:

Hospital: Provided

Clinic: Provided. Facility must be a licensed out-patient treatment clinic or surgical clinic.

Methadone: Not provided

D. Payment Information: Claims processed and paid by the Computer Company, Inc., acting as fiscal agent for the state.

E. Remarks: New program effective as of July 1, 1976. Basic condition of alcohol and/or drug abuse will not be covered. Only medical problems arising from these conditions will be covered. Drug abuse treatment programs, both inpatient and outpatient, are specifically excluded from Medicaid reimbursement by the state plan, except that withdrawal from drug addiction in a general hospital setting is covered when the nature of the recipient's addiction requires that withdrawal take place in a 24-hour general hospital setting in order to reduce serious risk to the recipient's health.

STATE Arkansas

Responsible State Agency: Division of Social Services

P. O. Box 1437, Little Rock, Arkansas 72203 (501) 371-2385
Address **Phone**

Suggested Personal Contact: Mr. Allan Cooper

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: District social service office

B. Provider Eligibility: Providers certified by state social service office. Written agreement between the state and individual practitioners required.

Services Covered:

Physician: Provided. Limited to 18 in-office visits. Additional services must be rendered at a hospital facility.

Psychiatrist: Provided. Same limitation as for physician.

Psychologist: Provided. Only for diagnostic purposes and when billed through a psychiatrist.

C. Facility Eligibility:

Services Covered:

Hospital: Provided. Limited to 26 days. Extension must have prior authorization.

Clinic: Provided. Only for diagnostic purposes and when billed through a psychiatrist.

Methadone: Provided

D. Payment Information: Processed and paid by State Department of Social Services. Drugs, including methadone, paid by Paid Prescriptions, Inc.

E. Remarks: By January 1, 1976, a program will be in effect between Arkansas State Medicaid and 13 (thirteen) Community Mental Health Centers whereby the state will pay for alcoholism and drug abuse treatment under Medicaid at those centers. Any drug abuse programs, whether public or private, must apply to the Arkansas Mental Health Program under standards formulated for community mental health programs.

STATE California

Responsible State Agency: California Department of Health — Medi-Cal

714 P Street, Room 1792, Sacramento, California 95814 (916) 445-1995
Address **Phone**

Suggested Personal Contact: Frank Tarantino, Roger King
Substance Abuse Health Treatment Division 332-6690

A. Client Eligibility: Categorically Needy
Medically Needy
Medically Indigent

Certified by: County Department of Benefit Payments

B. Provider Eligibility: California Department of Health-Medi-Cal certifies provider eligibility.

Services Covered:

Physician: Provided. Only acute detoxification covered in drug abuse cases.

Psychiatrist: Provided. Same as physician.

Psychologist: Provided. Limit of two visits per month of possessing "medi" labels.

C. Facility Eligibility: Prior authorization required for all nonemergency admissions to hospitals.

Services Covered:

Hospital: Provided. Only acute detoxification covered in drug abuse cases.

Clinic: Provided. Same limit as hospital.

Methadone: Provided, for detoxification only; no maintenance treatment is covered.

D. Payment Information: Processed and paid by fiscal intermediary (California Blue Cross and Blue Shield).

E. Remarks: Only attendant medical problems of drug abuse are covered. Any service deemed rehabilitative in nature is not allowed under Medicaid.

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STATE Colorado

Responsible State Agency: Department of Social Services

700 Broadway, Denver, Colorado 80203 (303) 892-3253

Address **Phone**

Suggested Personal Contact: Douglas T. Margrieter

A. Client Eligibility: Categorically Needy

Certified by: County Departments of Social Services

B. Provider Eligibility: Any licensed physician is eligible. Formal agreement are established with hospitals.

Services Covered:

Physician: Provided

Psychiatrist: Provided

Psychologist: Not provided unless under direct supervision of psychiatrist or physician.

C. Facility Eligibility:

Services Covered:

Hospital: Provided

Clinic: Not provided

Methadone: Not provided

D. Payment Information: Blue Cross & Blue Shield of Colorado serve as fiscal administrators.

E. Remarks: Drug abuse treatment is specifically excluded from Medicaid coverage in Colorado. All drug abuse reimbursement must be under title XX.

STATE Connecticut

Responsible State Agency: Department of Social Services

100 Asylum Avenue, Hartford, Connecticut 06105 (203) 566-3814
Address **Phone**

Suggested Personal Contact: Ms. Marie Misenti

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: Local offices of Department of Social Services

B. Provider Eligibility: Providers certified by the State Department of Social Services. Claim form serves as legal agreement.

Services Covered: Prior authorization required for psychiatrist's or psychologist's services except in cases of extreme emergency.

Physician: Provided

Psychiatrist: Provided

Psychologist: Provided. Limited to $22 per patient for diagnostic services. Limited to $10 for counseling and psychotherapy and $20 for individual counseling and psychotherapy.

C. Facility Eligibility: All facilities must sign provider agreement with the state in order to render services to Medicaid recipients.

Services Covered:

Hospital: Provided

Clinic: Provided. Must be physician-directed.

Methadone: Provided, if a medical facility.

D. Payment Information: Processed and paid by the State Department of Social Services.

E. Remarks: Medical problems that are caused by drug abuse or alcoholism can be treated under Connecticut State Medicaid but not the addiction itself. Detoxification and rehabilitation for drug abuse are specifically excluded. The impairment must be of major significance in order to have the individual meet the title II or title XVIII "Disability" requirement for title XIX eligibility.

STATE Delaware

Responsible State Agency: Department of Public Welfare; Division of Social Services

P. O. Box 309, Wilmington, Delaware 19899 (302) 571-3139
Address **Phone**

Suggested Personal Contact: Ms. Mary Lee Berry, Division of Social Services
Mr. Martin Golden (Pharmacy Control Officer, Div. of Public Health, Dover, Delaware)

A. Client Eligibility: Categorically Needy

Certified by: Division of Social Services

B. Provider Eligibility: State Division of Social Services of Delaware Department of Public Welfare certifies providers. Providers agreement required between the state and providers.

Services Covered:

Physician: Provided

Psychiatrist: Provided. Limited to one visit.

Psychologist: Not provided

C. Facility Eligibility: Must possess valid provider agreement with State Department of Public Welfare.

Services Covered:

Hospital: Provided. Illness-specific limits imposed.

Clinic: Provided

Methadone: Provided (in limited cases). Prior authorization required from Division of Drug Abuse Control.

D. Payment Information: Processed and paid by Blue Cross and Blue Shield of Delaware.

E. Remarks: Drug abuse treatment services are not included in the state plan. The only methadone maintenance program being covered by Medicaid (as of 11/75) is in the Wilmington Medical Center, which has a special arrangement with the Office of Drug Abuse Control in the Division of Mental Health. In this instance Medicaid is paying for the drug and the service only, since psychologists' services or psychiatric therapy are not covered services.

STATE District of Columbia

Responsible State Agency: Department of Human Resources

500 1st Street, N. W., Washington, D. C. 20001 (202) 629-6601

Address **Phone**

Suggested Personal Contact: Mr. Peter Coppola, Payment Assistance Administration (202) 629-6674

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: Bureau of Eligibility Determination; Department of Human Resources

B. Provider Eligibility: Legal agreement required between medical assistance unit of Department of Human Resources and providers.

Services Covered:

Physician: Provided

Psychiatrist: Provided

Psychologist: Provided, but only in authorized clinics.

C. Facility Eligibility:

Services Covered:

Hospital: Provided

Clinic: Provided

Methadone: Provided, in clinic setting only.

D. Payment Information: Payment Assistance Administration of Department of Human Resources processes and pays claims from providers.

E. Remarks: Rehabilitation covered in clinic setting. Drug abuse treatment programs must meet the standards established for free-standing clinics in order to be reimbursed. Medicaid also reimburses centers administered by the Narcotics Treatment Administration of the D. C. Government as well as inpatient services at hospitals for acute patients.

STATE Florida

Responsible State Agency: Department of Health and Rehabilitation Services

P. O. Box 2050, Jacksonville, Florida 32203 (904) 725-3080

Address **Phone**

Suggested Personal Contact: Mr. Charles Busby

A.	**Client Eligibility:**	Categorically Needy
	Certified by:	County Departments of Health and Rehabilitation Services
B.	**Provider Eligibility:**	Providers licensed by Health Programs Office of the Department of Health and Rehabilitation Services.
	Services Covered:	Prior authorization required for every occasion of service through statewide rapid communications network.
	Physician:	Provided
	Psychiatrist:	Provided
	Psychologist:	Not Provided
C.	**Facility Eligibility:**	Participation agreement between facilities and Health Programs Office required.
	Services Covered:	Prior authorization through statewide rapid communications computer network required for each occasion of service.
	Hospital:	Provided. Limited to 30 days.
	Clinic:	Not Provided
	Methadone:	Not Provided
D.	**Payment Information:**	State Department of Health and Rehabilitation Services processes and state comptroller pays claim. Paid Prescriptions, Inc., pays for all drugs allowed under state Medicaid guidelines.
E.	**Remarks:**	There are no provisions for Medicaid reimbursement of drug abuse treatment in the state plan. Florida policy is to adhere rigidly to planning guidelines. Legislative action to amend the state plan would therefore be required to include drug abuse under Medicaid coverage.

STATE Georgia

Responsible State Agency: Department of Human Resources

618 Ponce de Leon Ave., N. E., Atlanta, Georgia 30308 (404) 894-5167
Address **Phone**

Suggested Personal Contact: Sam Thurmond or Mrs. Frances Lipscomb 894-5167

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: County Department of Human Resources and Social Security Administration

B. Provider Eligibility: State Department of Human Resources certifies providers. Provider agreement between the state and providers required.

Services Covered:

Physician: Provided

Psychiatrist: Provided. Limited to $250 per patient per year.

Psychologist: Provided. Must be referred by a physician or casework agency.

C. Facility Eligibility: Provider agreement between the state and facilities required.

Services Covered:

Hospital: Provided

Clinic: Provided for mental health services only.

Methadone: Not Provided

D. Payment Information: Processed and paid by State Department of Human Resources.

E. Remarks: Outpatient drug abuse treatment programs are covered only if they are administered by an agency of the state or local government. Community Mental Health Centers comprise the large majority of these programs. Attendant problems of drug abuse may be covered on an inpatient basis but not detoxification or rehabilitation services.

STATE Hawaii

Responsible State Agency: Department of Social Services and Housing

P. O. Box 339, Honolulu, Hawaii 96809 (808) 548-6584
Address **Phone**

Suggested Personal Contact: Mr. Yoshimura

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: County Departments of Social Services

B. Provider Eligibility: State Department of Social Services certifies providers. Claim form serves as legal agreement tween the state and individual practitioners.

Services Covered:

Physician: Provided

Psychiatrist: Provided. Limited to four visits per year. Extensions must have prior authorization.

Psychologist: Provided. Limited to clinical psychologist only.

C. Facility Eligibility: Provider agreement required between the state and facilities.

Services Covered:

Hospital: Provided.* Limited to 8 days. Extensions must have prior authorization. Psychiatric admissions limited to 10 days. Extensions to 18 days with prior authorization.

Clinic: Provided

Methadone: Provided. State pays $10 per patient (drug and urinalysis costs).

D. Payment Information: Processed and paid by Hawaii Medical Services Association (Blue Cross and Blue Shield).

E. Remarks: *Extended inpatient care beyond initial stay determined by attending physician subject to approval by Department of Social Services. Drug abuse programs are allowed provider status under Hawaii state Medicaid. Treatment programs wishing a provider number must demonstrate an effective treatment record and be able to meet criteria established for free-standing clinics. No inpatient drug abuse programs outside of state-licensed hospitals are covered by Medicaid.

STATE Idaho

Responsible State Agency: Department of Health and Welfare

650 W. State Street, Boise, Idaho 83720 (208) 384-3944
Address **Phone**

Suggested Personal Contact: Mr. Karl Banschbach, Medical Assistance Section

A. Client Eligibility: Categorically Needy

Certified by: Regional and local offices of the Department of Health and Welfare

B. Provider Eligibility: Any licensed physician is eligible.

Services Covered:

Physician: Provided

Psychiatrist: Provided

Psychologist: Provided only through mental health clinic setting.

C. Facility Eligibility: Contract needed for long-term care services.

Services Covered:

Hospital: Provided, limited to 20 days.

Clinic: Not provided unless qualifying under intermediate care program.

Methadone: Provided, maximum benefit of $20 per month.

D. Payment Information: Processed by State Department of Health and Welfare.

E. Remarks: Rehabilitation provided for in clinic setting. Department of Health and Welfare works in conjunction with Vocational Rehabilitation Program. There is no formal procedure at the moment for covering drug treatment programs under Idaho Medicaid. As of January 1976 the drug treatment unit of Social Services Division was attempting to establish state licensing for drug abuse programs and a method for reimbursing them under Medicaid.

STATE Illinois

Responsible State Agency: Department of Public Aid

316 South 2nd Street, Springfield, Illinois 62762 (312) 341-7984
Address **Phone**

Suggested Personal Contact: Mrs. Violette Anderson

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: Department of Public Aid

B. Provider Eligibility: Providers certified by Illinois Department of Public Health. Provider agreement required between individual providers and Department of Public Aid.

Services Covered:

Physician: Provided

Psychiatrist: Provided

Psychologist: Provided if referred to by a physician.

C. Facility Eligibility: Certified by Department of Public Health. Psychiatric facilities certified by Department of Mental Health.

Services Covered:

Hospital: Provided

Clinic: Provided

Methadone: Provided, if prescribed by physician.

D. Payment Information: Processed through state comptroller by State Department of Public Aid.

E. Remarks: As of January 1976, the only reimbursement for drug abuse treatment was for individuals seeking treatment at state mental health centers. All other drug treatment programs reimbursed by social services division under title XX.

STATE Indiana

Responsible State Agency: Department of Public Welfare

1000 North Senate Avenue, Indianapolis, Indiana 46204 (317) 633-5582

Address **Phone**

Suggested Personal Contact: Mr. George Nichols

A. **Client Eligibility:** Categorically Needy

Certified by: County welfare departments

B. **Provider Eligibility:** State Board of Health certifies providers. A provider agreement between individuals and the state board of health is required.

Services Covered:

Physician: Provided. Limited to 20 office visits per year. Individual authorization required thereafter.

Psychiatrist: Provided. Same limits as physician.

Psychologist: Provided. Must be referred by physician.

C. **Facility Eligibility:**

Services Covered:

Hospital: Provided

Clinic: Provided

Methadone: Provided, on outpatient basis when prescribed by physician.

D. **Payment Information:** Claims processed by Blue Cross and Blue Shield (Mutual Medical Insurance, Inc.).

E. **Remarks:** Rehabilitation on outpatient basis provided in certain programs. Drug abuse treatment programs must be inspected and licensed by the department of health. Those programs so licensed can be considered for provider status. Medicaid also reimburses drug abuse programs affiliated with Community Mental Health Centers. Inpatient treatment is reimbursed through general hospitals only.

STATE Iowa

Responsible State Agency: Department of Social Services

Lucas State Office Bldg., 4th FLOOR, Des Moines, Iowa 50319 (515) 281-5755
Address **Phone**

Suggested Personal Contact: Dr. Elmer Smith

A. Client Eligibility: Categorically Needy

Certified by: County Department of Social Services

B. Provider Eligibility: Provider certification handled by Blue Cross and Blue Shield. Claim form serves as legal agreement.

Services Covered:

Physician: Provided

Psychiatrist: Provided

Psychologist: Provided, if employed by a psychiatrist.

C. Facility Eligibility: Iowa State Health Department certifies facility eligibility. A provider agreement between the state and treatment facilities is required.

Services Covered:

Hospital: Provided

Clinic: Provided. Must be physician-directed.

Methadone: Not provided

D. Payment Information: Paid and processed by Blue Cross and Blue Shield of Iowa.

E. Remarks: Iowa Medicaid covers medical problems attendant to drug abuse and/or addiction only. Treatment of the addiction itself, whether detoxification or rehabilitative services, is specifically excluded.

STATE Kansas

Responsible State Agency: Department of Social and Rehabilitation Services

State Office Building, Topeka, Kansas 66612 (913) 296-3959

Address **Phone**

Suggested Personal Contact: Dr. P. L. Biederwell

A. Client Eligibility: Categorically Needy

Certified by: District offices of Department of Social Welfare

B. Provider Eligibility: Certified by Kansas Blue Cross and Blue Shield. All licensed physicians are eligible.

Services Covered:

Physician: Provided

Psychiatrist: Provided

Psychologist: Provided, if an employee of a mental health facility, hospital, or physician.

C. Facility Eligibility: Hospitals must be Medicare/Medicaid eligible.

Services Covered:

Hospital: Provided

q **Clinic:** Provided

Methadone: Provided, in clinic setting.

D. Payment Information: Kansas Blue Cross and Blue Shield acts as fiscal intermediary for State Department of Administration.

E. Remarks: Outpatient drug abuse treatment programs could be given provider status if they met the criteria for free-standing clinics or were coordinated through a community mental health program. All inpatient facilities must be Medicare eligible. There is one residential drug treatment program in Topeka that is reimbursed by Medicaid for all medically necessary services. The county government is reimbursing residential costs.

STATE Kentucky

Responsible State Agency: Dept. for Human Resources; Bureau for Social Improvement

Frankfort, Kentucky 40601 (502) 564-5560

Address **Phone**

Suggested Personal Contact: Ed Boggs

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: County Bureau for Social Insurance

B. Provider Eligibility: Providers certified by State Department for Human Resources. Provider agreement required between the state and all providers.

Services Covered:

Physician: Provided. Limited to two initial visits per patient per year. Routine visits are unlimited. Extensions must be verified as to medical need.

Psychiatrist: Provided. Must be Board certified.

Psychologist: Provided. Only in comprehensive care centers certified as Medicaid eligible.

C. Facility Eligibility:

Services Covered:

Hospital: Provided, for up to 7 days after which case is reviewed; if extended, 21 days is maximum.

Clinic: Not provided

Methadone: Not provided

D. Payment Information: Processed and paid by Division of Medical Assistance

E. Remarks: Drug abuse treatment is reimbursed by Medicaid through Community Mental Health Centers. Only professional services covered however (physician, psychiatrist, psychologist, psychiatric nurse and M.S. social worker) for outpatients. Inpatient drug abuse treatment services are reimbursed by Medicaid.

STATE Louisiana

Responsible State Agency: Department of Public Welfare

P. O. Box 44065, Baton Rouge, Louisiana 70804 (504) 389-6064

Address **Phone**

Suggested Personal Contact: Neal D. Blanchard, M.D.

A. Client Eligibility: Categorically Needy

Certified by: Division of Family Services - Health and Human Resources Administration

B. Provider Eligibility: Certified by Division of Family Services. All licensed physicians are eligible. Contract required between facilities and state of Louisiana, but not required of physicians.

Services Covered:

Physician: Provided. Limited to 12 visits per year. Prior authorization from Physician Review Board needed for continuances.

Psychiatrist: Provided

Psychologist: Provided, but only through drug abuse or mental health centers.

C. Facility Eligibility:

Services Covered:

Hospital: Provided

Clinic: Provided, if under direction of physician and billed by him.

Methadone: Not provided

D. Payment Information: Division of Family Services processes Medicaid payments. Medicare payments processed by Pan-American Life Insurance Company of New Orleans.

E. Remarks: Rehabilitation therapy provided for physical and mental problems if prescribed by a physician. Reimbursement for methadone is specifically prohibited by the state plan. Drug abuse treatment programs can be covered by Medicaid if they meet the criteria established for free-standing clinics or if they qualify as a mental health center.

STATE Maine

Responsible State Agency: Department of Human Services

Augusta, Maine 44330 (207) 289-1110

Address **Phone**

Suggested Personal Contact: Mrs. Alice Ladd, Medical Services Specialist

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: Regional offices of Department of Human Services

B. Provider Eligibility: Department of Human Services certifies all providers. Psychiatrists must be certified by Maine Board of Psychiatrists.

Services Covered:

Physician: Provided

Psychiatrist: Provided. Private counseling, group therapy, crisis intervention.

Psychologist: Provided

C. Facility Eligibility:

Services Covered:

Hospital: Provided

Clinic: Provided if clinic is contracted with the state. Only one clinic may be contracted in any single locality.

Methadone: Provided

D. Payment Information: Processed by State Accounting Office. Drug processed by Paid Prescriptions.

E. Remarks: There were no independent outpatient drug abuse treatment programs receiving Medicaid reimbursement as of December 1975. There have been no applicants in the past and no policy regarding drug abuse treatment has been formulated. The State Vocational Rehabilitation office is covering most of the drug abuse treatment in Maine.

STATE Maryland

Responsible State Agency: Department of Health and Mental Hygiene

State Office Building, Room 1202, Baltimore, Maryland 21201 (301) 383-2658
Address **Phone**

Suggested Personal Contact: Mr. Robert D. Wilcox, Dr. List (383-3963)

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: State Department of Social Services

B. Provider Eligibility: Certified by Maryland State Medical Care Program: A certificate signed by the attending physician and submitted with bill for services rendered serves as agreement application required for individual physicians.

Services Covered:

Physician: Provided

Psychiatrist: Provided

Psychologist: Not provided

C. Facility Eligibility:

Services Covered: Limited to 21 days for Medically Needy.

Hospital: Provided. (28-day maximum for mental problems, 7-day maximum for drug detoxification)

Clinic: Provided, if under contract with the state.

Methadone: Provided, if under the direction of a physician.

D. Payment Information: Processed by Medical Assistance Operations Administration (State Department of Health).

E. Remarks: Outpatient drug abuse treatment programs are covered as free-standing clinics. The Institutional Care Division of the Department of Health and Mental Hygiene passes on the suitability of programs and establishes provider numbers. There is one inpatient program with two beds being reimbursed by Medicaid through special arrangements (as of 11/75). All other inpatient services covered are through hospitals.

STATE Massachusetts

Responsible State Agency: Department of Public Welfare

600 Washington Street, Boston, Massachusetts 02111 (617) 727-7538
Address **Phone**

Suggested Personal Contact: Mrs. Gladys Tynes

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: Local Department of Public Welfare certifies provider eligibility. Purchase of services agreement required between the state and all providers.

B. Provider Eligibility:

Services Covered:

Physician: Provided

Psychiatrist: Provided

Psychologist: Provided. For diagnostic purposes or in a certified clinic setting.

C. Facility Eligibility:

Services Covered:

Hospital: Provided

Clinic: Provided. Limited to 10 sessions for mental health clinics, after which prior approval from the state is necessary.

Methadone: Provided. Only in a hospital, on an inpatient basis.

D. Payment Information: Processed and paid by State Department of Public Welfare.

E. Remarks: State Medicaid is examining the possibility of reimbursing drug treatment programs that meet the criteria established for free-standing clinics. None were covered in this matter as of December 1975. The only drug abuse outpatient treatment covered is through Community Mental Health Centers on an individual basis. Inpatient drug abuse treatment is allowed only in certified hospitals.

STATE Michigan

Responsible State Agency: Department of Social Services

State Capital, Capital Street, Lansing, Michigan 48933 (517) 373-7605
Address **Phone**

Suggested Personal Contact: Eileen McCauley

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: County Departments of Social Services

B. Provider Eligibility: All providers must be licensed by the Department of Licensing and Regulations and a provider agreement established with the Department of Social Services.

Services Covered:

Physician: Provided

Psychiatrist: Provided. Limited to 10 outpatient visits per year other than for diagnosis of drug abuse or alcoholism

Psychologist: Limited to psychological testing services, if billed by a physician.

C. Facility Eligibility:

Services Covered:

Hospital: Provided

Clinic: Provided. Physicians in a clinic setting are reimbursed on an individual basis.

Methadone: Provided

D. Payment Information: Processed by Michigan State Department of Social Services.

E. Remarks: Methadone maintenance programs must provide a minimum of 15 doses per patient per calendar month in other to qualify for reimbursement. These programs must also provide other medication for withdrawal management. Payment is made on the flat fee schedule of $50 per patient per month. Drug abuse programs not providing methadone are reimbursed only for physician's services. All drug abuse programs must be licensed and approved by the Office of Substance Abuse and Alcoholism of the Health Department.

STATE Minnesota

Responsible State Agency: Department of Welfare; Medical Assistance Program

690 N. Roberts, Box 30170, St. Paul, Minnesota 55175 (612) 296-7666

Address **Phone**

Suggested Personal Contact: Ms. Irene Goldman

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: County Medical Assistance Office

B. Provider Eligibility: State Medical Assistance Program, Department of Welfare certifies providers. Provider agreement is required between the state and all providers.

Services Covered:

Physician: Provided

Psychiatrist: Provided. Limited to 12 visits. Extensions require prior approval.

Psychologist: Provided

C. Facility Eligibility:

Services Covered:

Hospital: Provided

Clinic: Provided. Must be physician directed.

Methadone: Provided

D. Payment Information: Processed and paid by State Department of Welfare.

E. Remarks: Physician directed drug abuse programs may be covered by Medicaid if they meet the standards formulated for free-standing clinics. Psychologist directed programs must be billed through the psychologist and be directly supervised by him. Minnesota state Medicaid will also reimburse drug abuse programs that qualify as mental health centers. When claiming FFP, these services are cited as either physician services or other licensed practitioner services.

STATE Mississippi

Responsible State Agency: Mississippi Medicaid Commission

P. O. Box 5160, Jackson, Mississippi 39216 (601) 354-7464
Address **Phone**

Suggested Personal Contact: William Allen

A. Client Eligibility: Categorically Needy

Certified by: State Department of Public Welfare

B. Provider Eligibility: Providers certified by Mississippi Medicaid Commission.

Services Covered: All physicians qualify as providers. Claim forms serve as business agreements.

Physician: Provided

Psychiatrist: Provided. Limited to $250 per fiscal year.

Psychologist: Not provided

C. Facility Eligibility: Contract with State Medicaid Commission required.

Services Covered:

Hospital: Provided

Clinic: Not provided

Methadone: Provided. May be covered if prescribed by physician.

D. Payment Information: Mississippi Blue Cross and Blue Shield act as intermediaries for Medicaid claims.

E. Remarks: The State of Mississippi specifically limits the uses to which Medicaid money may be applied. Drug abuse treatment programs are not covered by Medicaid at the present and the State Medicaid Commission would not consider funding same without further legislative expansion of Medicaid provisions within the state.

STATE Missouri

Responsible State Agency: Department of Public Health and Welfare

Broadway State Office Building, W. High Street (314) 751-2151

Address Jefferson City, Missouri 65101 **Phone**

Suggested Personal Contact: Mr. Thomas Singleton; Mr. Gary Bailey - 751-3425

A. Client Eligibility: Categorically Needy

Certified by: County Division of Family Services

B. Provider Eligibility: Certified by Medical Services Section, Division of Family Services. Contract between all providers and Division of Family Services required.

Services Covered:

Physician: Provided

Psychiatrist: Provided

Psychologist: Provided only when employed by a physician.

C. Facility Eligibility:

Services Covered:

Hospital: Provided. Maximum of 21 days per admission.

Clinic: Not provided

Methadone: Not provided unless prescribed by physician.

D. Payment Information: Processed and paid by the Family Services Division of the Department of Social Services.

E. Remarks: Any drug abuse program wishing to gain provider status under Medicaid would have to obtain Federal funds first and apply to Medicaid for funds on a cash match basis. This is the only possible avenue for funding at the present time.

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STATE Montana

Responsible State Agency: Department of Social and Rehabilitation Services

State Capital, Helena, Montana 59601 — (406) 449-2031

Address — **Phone**

Suggested Personal Contact: Bill Ikard, Medical Director

A. **Client Eligibility:** Categorically Needy
Medically Needy

Certified by: County welfare offices of the State Department of Social and Rehabilitation Services.

B. **Provider Eligibility:** Providers are certified by the Medical Assistance Bureau.

Services Covered:

Physician: Provided

Psychiatrist: Provided

Psychologist: Provided. Limited to 22 hours per fiscal year.

C. **Facility Eligibility:** Contract with state required for all facilities.

Services Covered:

Hospital: Provided. 30 days per year per patient. Must be certified by Montana Foundation for Medical Care.

Clinic: Provided

Methadone: Provided but only in hospital setting or by individual physician. No clinics in state.

D. **Payment Information:** Processed by Dikewood Corporation.

E. **Remarks:** There have been no instances of a drug abuse program's applying for provider status in Montana. The state plan does not exclude it, however, and a program meeting the criteria for a free-standing clinic would probably receive reimbursement for services covered in that category.

STATE Nebraska

Responsible State Agency: Department of Public Welfare

1526 K Street, Lincoln, Nebraska 68508 (402) 471-2384

Address **Phone**

Suggested Personal Contact: Donald F. Hogg; Mr. Clinton Belknapp

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: County Department of Public Welfare

B. Provider Eligibility: State Department of Public Welfare certifies providers. Provider agreement required between the state and all providers.

Services Covered:

Physician: Provided

Psychiatrist: Provided. Limited to 30 hours per year.

Psychologist: Provided. Limited to diagnostic purposes with referral from a physician.

C. Facility Eligibility: Provider agreement between the state and facilities required.

Services Covered:

Hospital: Provided. Psychiatric patients limited to 10-day stay. Extensions up to 30 days allowed with prior approval.

Clinic: Provided. Must be supervised by a physician.

Methadone: Provided

D. Payment Information: Processed and paid by State Department of Public Welfare.

E. Remarks: The state health department licenses drug abuse programs, after which the program may apply for provider status with the Department of Public Welfare under criteria formulated for free-standing clinics. The only method by which an inpatient drug abuse facility could become a provider would be through a cooperative agreement with a provider hospital whereby the program bills for services through the hospital's provider number.

STATE Nevada

Responsible State Agency: Department of Human Resources

251 Jeanell Drive, Carson City, Nevada 89710 (702) 885-4775

Address **Phone**

Suggested Personal Contact: Steven P. Bradford, Pharmaceutical Consultant

A. Client Eligibility: Categorically Needy

Certified by: District offices of State Welfare Division, Department of Human Resources

B. Provider Eligibility: Certified by Central Office, Department of Human Resources. Contract between all providers and Department of Human Resources required.

Services Covered:

Physician: Provided

Psychiatrist: Provided

Psychologist: Provided. Prior authorization from State Department of Human Resources required.

C. Facility Eligibility:

Services Covered:

Hospital: Provided

Clinic: Provided

Methadone: Provided

D. Payment Information: Processed and paid by Nevada Blue Shield.

E. Remarks: There is only one methadone maintenance clinic in Nevada. It is located in the Clark County District Health Department. An interagency agreement exists between the Welfare Division and the Rehabilitation Division in Department of Human Resources covering medical costs incurred during rehabilitation. No other drug abuse programs have applied for Medicaid. All applicants will be individually reviewed. Drug abuse programs would have to meet criteria for free-standing clinics to be considered. All psychological care would need prior authorization. Any inpatient facility must first be eligible for Medicare.

STATE New Hampshire

Responsible State Agency: Department of Health and Welfare

8 Loudon Road, Concord, New Hampshire 03301 (603) 271-2382

Address **Phone**

Suggested Personal Contact: Mr. Maurice Goulet

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: Local Department of Welfare

B. Provider Eligibility: Office of Provider Relations of the Division of Welfare certifies providers. A formal agreement is required between the provider and the state.

Services Covered:

Physician: Provided

Psychiatrist: Provided. All visits require prior approval.

Psychologist: Provided. All visits require prior approval.

C. Facility Eligibility:

Services Covered:

Hospital: Provided. Limited to 12 days. Extensions require prior approval.

Clinic: Not provided.

Methadone: Unknown. There is only one methadone program in the state and no one has applied for Medicaid reimbursement in connection with it.

D. Payment Information: Processed and paid by the New Hampshire Medicaid Management Information System.

E. Remarks: The Drug Abuse Program of the New Hampshire Division of Health finances drug abuse treatment programs through state grants. No Medicaid money can go to these programs because of prohibitions on duplication of payments. Drug abuse treatment programs not funded by the state would need a federal cash grant for which they could apply to Medicaid for matching funds. This has never been attempted but remains the only possible method for Medicaid reimbursement.

STATE New Jersey

Responsible State Agency: Department of Institutions and Agencies

324 E. State Street, Trenton, New Jersey 08608 (609) 292-8199

Address **Phone**

Suggested Personal Contact: Dr. Edward Wallerstien, Chief, Bureau of M.H. Services; Helen Jones (201) 289-1935

A. **Client Eligibility:** Categorically Needy

Certified by: County Welfare Boards and Social Security Administration.

B. **Provider Eligibility:** Certified by State Division, Medical Assistance and Health Services.

Services Covered:

Physician: Provided

Psychiatrist: Provided. Limited to $300 per fiscal year. Prior authorization required for further treatment.

Psychologist: Provided

C. **Facility Eligibility:** All facilities must sign provider agreements.

Services Covered:

Hospital: Provided

Clinic: Provided, subject to licensing by State Department of Health.

Methadone: Specifically prohibited

D. **Payment Information:** Long-term care facilities paid by the state. Blue Cross of New Jersey reimburses pharmacies and most hospitals that are receiving reimbursement under Medicaid. Prudential Life Insurance Company reimburses the rest.

E. **Remarks:**

Medical problems are only covered services. Drug abuse rehabilitation is not included in services reimbursed. However, there is one drug abuse program that applied for provider eligibility as a family health center and was accepted because of its wide range of medical services; Medicaid pays $10 per patient visit.

STATE New Mexico

Responsible State Agency: Health and Social Services Department

P. O. Box 2348, Santa Fe, New Mexico 87503 (505) 827-2401

Address **Phone**

Suggested Personal Contact: Richard Atkinson

A. Client Eligibility: Categorically Needy

Certified by: Health and Social Services Department

B. Provider Eligibility: Certified by the state Health and Social Services Department. The provider's claim form serves as a contract.

Services Covered:

Physician: Provided

Psychiatrist: Provided. After initial visit, prior approval with the state Professional Standards Review Organization is required.

Psychologist: Provided. Requires approval after initial evaluation.

C. Facility Eligibility: Written agreement necessary between free-standing clinics and the Department of Health and Social Services.

Services Covered:

Hospital: Provided

Clinic: Provided

Methadone: Not provided unless prescribed as an analgesic in a hospital.

D. Payment Information: Processed by Dikewood Corporation, which serves as the fiscal agent.

E. Remarks: Drug abuse treatment outside of hospital settings has never been covered under Medicaid in New Mexico. This has been the policy of the state agency rather than through any specific exclusion in the state plan.

STATE New York

Responsible State Agency: Department of Social Services

74 State Street, Albany, New York 12207 (518) 457-3761
Address **Phone**

Suggested Personal Contact: Mrs. Catherine P. Moylan

A. Client Eligibility: Categorically Needy
Medically Needy. Limited to inpatient hospital services.

Certified by: District offices of Department of Social Services

B. Provider Eligibility: State Department of Education certifies individual practitioners as providers. The providers claim form serves as an agreement.

Services Covered:

Physician: Provided

Psychiatrist: Provided. Prior authorization from District Medical Director is required.

Psychologist: Provided. Must be referred by a physician, and have received prior authorization from the District Medical Director.

C. Facility Eligibility: The State Department of Health certifies facilities as providers. No formal contract is utilized between the state and facilities.

Services Covered:

Hospital: Provided. Length of a stay norms for each illness have been established by the state.

Clinic: Provided

Methadone: Provided

D. Payment Information: State Department of Social Services supervises the processing and payment of claims.

E. Remarks: Drug abuse treatment is covered on a clinic basis if the program meets the standards for an ambulatory clinic. Inpatient programs can be reimbursed for physician-directed medical services if there are other funds covering residential costs. Otherwise reimbursement is limited to programs operating within general hospitals. Community Mental Health Centers can be reimbursed for eligible individuals whose drug abuse problem is considered a part of a larger psychiatric condition.

STATE North Carolina

Responsible State Agency: Department of Social Services

Albermarle Building, Raleigh, North Carolina 27611 (919) 829-2060
Address **Phone**

Suggested Personal Contact: Benny Ridout, Pharmacy Consultant

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: County Departments of Social Services

B. Provider Eligibility: The State Department of Social Services certifies providers. The claim form serves as an agreement for individual providers.

Services Covered:

Physician: Provided

Psychiatrist: Provided. Limited to 2 visits and only with prior authorization from the state.

Psychologist: Provided, if at the request of a physician.

C. Facility Eligibility: Purchase of Services Agreement required between facilities and the State Department of Social Services.

Services Covered:

Hospital: Provided

Clinic: Not provided

Methadone: Not provided

D. Payment Information: Processed and paid by Health Application Systems.

E. Remarks: Any drug abuse treatment program seeking provider status would have to present a comprehensive plan and budget to the Board of Social Services. The program should also provide evidence of some kind of federal funding and apply for state funds on a cash match basis.

STATE North Dakota

Responsible State Agency: Social Service Board of North Dakota

Capital Building, Bismark, North Dakota 58501 (701) 224-2321

Address **Phone**

Suggested Personal Contact: Richard Myatt

A. **Client Eligibility:** Categorically Needy
Medically Needy

Certified by: County Welfare boards

B. **Provider Eligibility:** No written agreement, routinely required between providers and the state, except as provided on the claims form to meet minimum federal requirements. Agreements are required on the part of long-term care facilities, pharmacies, and dentists to identify special conditions of participation.

Services Covered:

Physician: Provided

Psychiatrist: Provided

Psychologist: Not provided

C. **Facility Eligibility:**

Services Covered:

Hospital: Provided

Clinic: Provided

Methadone: Not provided*

D. **Payment Information:** County welfare boards issue authorization forms that are completed by the provider. The provider then forwards the claim to the state welfare board, which processes and pays the claim.

E. **Remarks:** Rehabilitation for persons under 21 is covered by Medicaid.

*There are no methadone programs in North Dakota at the present time. There is no policy as to methadone coverage. Drug abuse programs meeting criteria for free-standing clinics could possibly become providers. However, no programs have attempted to do so as yet. All inpatient drug abuse treatment must be within licensed general hospital.

STATE Ohio

Responsible State Agency: Department of Public Welfare; Division of Medical Association

30 East Broad Street, Columbus, Ohio 43215 (614) 466-2365

Address **Phone**

Suggested Personal Contact: Joe Hoffer; Stanley Sells

A. Client Eligibility: Categorically Needy

Certified by: County Department of Public Welfare

B. Provider Eligibility: The provider certification unit of State Department of Public Welfare is responsible for all providers. All providers are required to sign a formal agreement.

Services Covered:

Physician: Provided

Psychiatrist: Provided

Psychologist: Provided

C. Facility Eligibility: Purchase of Services Agreement required with the state.

Services Covered:

Hospital: Provided. Limited to 90 days per spell of illness.

Clinic: Provided. Must be certified by State Health Department.

Methadone: The drug itself is not provided but a maximum of up to 10 visits per month is allowed for maintenance services.

D. Payment Information: Claims are processed and paid by the Ohio State Department of Public Welfare.

E. Remarks: Drug abuse treatment programs certified by the state health department are eligible for provider status if they meet the criteria for free-standing ambulatory clinics. Those programs dispensing methadone must have an agreement with the State Pharmacy Division and have a pharmacy number. Methadone maintenance is reimbursed on a fee for service basis.

STATE Oklahoma

Responsible State Agency: Department of Social and Rehabilitative Services

P. O. Box 25352, Oklahoma City, OK 73125 (405) 521-3801

Address **Phone**

Suggested Personal Contact: Dr. Bertha M. Levy

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: County offices of Department of Social and Rehabilitative Services. Billing form serves as agreement.

B. Provider Eligibility: Providers are certified by the State Department of Social and Rehabilitative Services.

Services Covered:

Physician: Provided. Limited to four office visits per month.

Psychiatrist: Provided. Limited to four visits per month and to a maximum of $500 per patient per year.

Psychologist: Provided only when referred by Early and Periodic Screening Program

C. Facility Eligibility: A formal contract between treatment facilities and the state is required.

Services Covered:

Hospital: Provided. Limited to 10 days. Extensions require prior approval after patient has been discharged.

Clinic: Not provided

Methadone: Not provided unless prescribed by physician as an analgesic.

D. Payment Information: Claims are processed by State Department of Social and Rehabilitative Services.

E. Remarks: There is no provision for drug abuse treatment in the state plan. Any inquiries would be addressed to the Medical Advisory Committee whose recommendation would be acted on by the Oklahoma Welfare Commission.

STATE Oregon

Responsible State Agency: Department of Human Resources; Public Welfare Division

Public Service Building, Salem, Oregon 97301 (503) 378-3694

Address **Phone**

Suggested Personal Contact: Bill Lowther

A. Client Eligibility: Categorically Needy

Certified by: Branch offices of the Department of Human Resources

B. Provider Eligibility: No contract is required between the state and individual providers. Certifications on provider check and invoice serve as agreement.

Services Covered: Elective therapy must have prior authorization.

Physician: Provided

Psychiatrist: Provided

Psychologist: Provided. Prior authorization required.

C. Facility Eligibility: No contract required between the state and facilities

Services Covered:

Hospital: Provided. Limited to 21 days per fiscal year per patient. Physician must certify in writing any hospitalization over 14 days unless approved by PSRO.

Clinic: Provided

Methadone: Provided. University of Oregon Medical School approves and supervises methadone programs and/or pharmacies dispensing the drug.

D. Payment Information: Processed and paid by the Department of Human Resources.

E. Remarks: Oregon Medicaid reimburses Community Mental Health Centers for drug abuse treatment elements in their programs.

STATE Pennsylvania

Responsible State Agency: Department of Public Welfare

Room 523, Health & Welfare Bldg., Harrisburg, PA. 17120 (717) 787-7362

Address **Phone**

Suggested Personal Contact: Mrs. Regina Dunkinson

A. Client Eligibility: Categorically Needy
Medically Needy - not eligible for drugs, equipment, appliances and prostheses

Certified by: County Departments of Public Welfare

B. Provider Eligibility: Medical Assistance Office of the State Department of Public Welfare certifies provider eligibility. Individual practitioners must apply and be screened by that office. No contract necessary with individual providers. Prior approval required for specialists or consultants.

Services Covered:

Physician: Provided. Limited to $6 per visit.

Psychiatrist: Provided. Limited to $6 per visit.

Psychologist: Not provided unless used for testing in a clinic setting.

C. Facility Eligibility: Contract between the state and eligible facilities required.

Services Covered:

Hospital: Provided. 60-day limit on hospital care. New benefit period begins when nonhospitalized for 60 days.

Clinic: Provided. Must be approved by state. $9.00 limit per patient.

Methadone: Provided

D. Payment Information: In-patient service claims are processed and paid by Blue Cross and Blue Shield. Services provided in a clinic setting or in the office of a private physician are processed by the Division of Finance, Department of Public Welfare.

E. Remarks:

Medically Needy school children can obtain drugs, etc., with prior approval. The Governor's Council on Drug and Alcohol Abuse approves and recommends drug abuse clinics to be providers (this includes methadone clinics). The council then notifies the Medicaid office which programs are to be included on the list of Medicaid eligible outpatient providers. The only inpatient drug abuse treatment programs currently covered are specialty care programs in hospitals.

STATE Rhode Island

Responsible State Agency: Department of Social and Rehabilitative Services

600 New London Avenue, Cranston, Rhode Island 02920 (401) 464-2177

Address **Phone**

Suggested Personal Contact: Mr. Anthony Lallo

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: Regional offices, Department of Social and Rehabilitative Services and the Social Security Administration for the S.S.I. Program

B. Provider Eligibility: Medical Standards and Review Office of State Social and Rehabilitative Services certifies provider eligibility. No contract between state and individual practitioners. Billing form serves as agreement.

Services Covered:

Physician: Provided. Limited to 2 visits per month for chronic conditions and 8 visits per month for acute conditions. Can be extended only by prior authorization.

Psychiatrist: Provided. Must be in own office. Ten visits over 3 month period allowed. Visits in addition to the initial visit require prior approval.

Psychologist: Not provided

C. Facility Eligibility: Contract or provider agreement required between facilities and state office.

Services Covered:

Hospital: Provided. Stays beyond 15 days require prior approval. Physician services on inpatient basis require prior approval after 37th day.

Clinic: Not provided

Methadone: Not provided. Administered through Mental Health & Retardation Hospitals

D. Payment Information: All claims are processed and paid by the State Department of Social and Rehabilitative Services.

E. Remarks: The state plan excludes all free-standing clinic programs from provider status.

STATE South Carolina

Responsible State Agency: Department of Social Services

Lady Street, Columbia, South Carolina 29202 (803) 758-2320

Address **Phone**

Suggested Personal Contact: Dr. William T. Leslie

A. Client Eligibility: Categorically Needy

Certified by: County Department of Social Services

B. Provider Eligibility: Providers certified by State Department of Social Services.

Services Covered:

Physician: Provided

Psychiatrist: Provided

Psychologist: Provided, but only if working for a state sponsored mental health clinic or picked up by physician as line item on his claim.

C. Facility Eligibility: Purchase of Services Agreement required between facilities and the state. Cost analysis report certified by a CPA required for facilities.

Services Covered:

Hospital: Provided. Limited to 40 days per fiscal year.

Clinic: Provided. Limited to outpatient psychiatric clinics and Community Mental Health Centers under supervision of South Carolina Mental Health Commission.

Methadone: Not provided*

D. Payment Information: Individual provider claims processed and paid by Blue Cross and Blue Shield of South Carolina. Claims from hospitals and clinics processed by Department of Social Services.

E. Remarks:
*Methadone maintenance program coverage has been proposed and should be realized in the immediate future. Department of Health and Environmental Control licenses all drug maintenance programs. To qualify as a Medicaid provider, a drug abuse program must be licensed by the above department and be certified as an outpatient psychiatric center. This means the program must be directed by a state certified psychiatrist and billed through his provider number.

STATE South Dakota

Responsible State Agency: Department of Public Welfare

Office of Medical Services, Capital Lake Plaza, Pierre, SD 57501 (605) 224-3495
Address **Phone**

Suggested Personal Contact: Arthur Fecht

A. Client Eligibility: Categorically Needy

Certified by: County or District Office of Assistance Payments, Division of Social Welfare

B. Provider Eligibility: State Division of Social Welfare, Medical Services Division certifies providers. Provider agreement required between the state and individual practitioners.

Services Covered:

Physician: Provided

Psychiatrist: Provided

Psychologist: Provided only in clinic setting when working for a psychiatrist.

C. Facility Eligibility: Provider agreement between facilities and the State required.

Services Covered:

Hospital: Provided. 30-day limit per spell of illness. No extensions.

Clinic: Not provided

Methadone: Not provided

D. Payment Information: Medical Services Division of the Department of Social Welfare processes and pays claims made by individual practitioners. Blue Cross and Blue Shield pays for inpatient and outpatient hospital services.

E. Remarks: Inpatient services that are deemed rehabilitative in nature must have prior authorization. Treatment for drug abuse or alcoholism is excluded from Medicaid coverage.

STATE Tennessee

Responsible State Agency: Department of Public Health

Ben Allen Road, Nashville, Tennessee 37216 (615) 741-7221
Address **Phone**

Suggested Personal Contact: Mr. Frank Jones

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: Medically Needy--Department of Human Services Aid to Families with Dependent Children--State Department of A.F.D.C.

B. Provider Eligibility: Providers certified by State Department of Public Health. Billing form serves as contract between state and individual providers.

Services Covered:

Physician: Provided

Psychiatrist: Provided

Psychologist: Not provided, except as an employee of a physician or through contractual arrangement with a physician.

C. Facility Eligibility: Application and legal agreement with state required for facilities.

Services Covered:

Hospital: Provided. Limited to 20 days per fiscal year.

Clinic: Provided

Methadone: Provided. Requires prior authorization. Drug treatment programs can become Medicaid providers if they apply under criteria established for Community Mental Health Centers to the Department of Mental Health. Methadone is allowed on an outpatient basis only in these centers.

D. Payment Information: Processed and paid by Blue Cross and Blue Shield of Tennessee. Equitable Life Assurance Society pays individual physicians and community mental health centers.

E. Remarks: The Department of Mental Health is in the process of establishing licensing standards for drug treatment programs that should be in effect by January 1977.

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STATE Texas

Responsible State Agency: Department of Public Welfare

John H. Reagan Building, Austin, Texas 78701 (512) 475-3575
Address **Phone**

Suggested Personal Contact: Dr. Phillip Gates, Mark Chevalier (512) 475-2541

A. Client Eligibility: Categorically Needy

Certified by: Local department of public welfare

B. Provider Eligibility: Certified by State Department of Public Welfare. Claim form serves as legal agreement between the state and individual practitioners.

Services Covered:

Physician: Provided. Two office visits per month allowed. Documentation of medical necessity required for extensions.

Psychiatrist: Provided. $500 limit per patient per calendar year.

Psychologist: Provided only if employed by a physician or if provided as part of inpatient hospital care for diagnostic purposes and billed by the hospital.

C. Facility Eligibility: Must be participating in Medicare program, then enter into provider agreement with the state.

Services Covered:

Hospital: Provided. Limited to 30 days. After 60 days lapse, 30 additional days are allowed.

Clinic: Not provided

Methadone: Not provided

D. Payment Information: Processed and paid by Blue Cross and Blue Shield of Texas. Drugs are paid for by State Department of Public Welfare.

E. Remarks: The state plan for Medicaid authorizes programs subject to funds allocated by the legislature. While drug abuse treatment is technically covered no funds have been made available and, therefore, no reimbursements are allowed for drug abuse treatment purposes.

STATE Utah

Responsible State Agency: Department of Social Services

74 State Street, Salt Lake City, Utah 84111 (801) 533-6522

Address **Phone**

Suggested Personal Contact: Sharon Wasek, Betty Johnson 533-5038

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: District Assistance Payments Offices of Department of Social Services

B. Provider Eligibility: Determined by Medical Claims and Services Office of state Department of Social Services

Services Covered:

Physician: Provided

Psychiatrist: Provided. Limited to 12 visits per illness. Extensions require prior authorization.

Psychologist: Provided. Limitation 12 (acute illness) visits/month; one (chronic illness) visit/month.

C. Facility Eligibility: Application form serves as legal agreement between the state and facilities.

Services Covered:

Hospital: Provided. Limited to 60 days per illness. Extensions require prior approval. All psychiatric illnesses over 12 days are reviewed by psychiatric consultant.

Clinic: Provided

Methadone: Provided. Utah Medicaid contributes $4.54 per patient to one methadone clinic in the state.

D. Payment Information: Processed and paid by Medical Claims Section of the Bureau of Finance, Division of Social Services.

E. Remarks: Drug treatment programs must be licensed by the Health Division of Department of Social Service, be recommended by the Division of Alcohol & Drug Abuse, and meet criteria established for free-standing clinics.

STATE Vermont

Responsible State Agency: Department of Social Welfare

State Street, Montpelier, Vermont 05602 (802) 828-3421

Address Phone

Suggested Personal Contact: Mr. Ray Shepard

A. **Client Eligibility:** Categorically Needy
Medically Needy

Certified by: District Offices of the Department of Social Welfare

B. **Provider Eligibility:** Providers are certified by Blue Cross and Blue Shield. Billing form serves as agreement between the state and all providers.

Services Covered:

Physician: Provided

Psychiatrist: Provided. Limited to $500 per year per patient. Prior authorization required for claims above that figure.

Psychologist: Provided. Must be referred to by a physician.

C. **Facility Eligibility:**

Services Covered:

Hospital: Provided

Clinic: Not provided

Methadone: Not provided

D. **Payment Information:** Processed and paid by Vermont/New Hampshire Blue Cross and Blue Shield.

E. **Remarks:** Eligibility of drug treatment programs has not been tested as there have been no applications from drug abuse treatment programs for provider status. The only drug abuse treatment reimbursed by Medicaid (as of 11/75) was on inpatient basis in a general hospital, limited to attendent psychiatric problems.

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STATE Virginia

Responsible State Agency: Department of Health, Virginia Medical Assistance Program

109 Governor Street, Richmond, Virginia 23219 (804) 786-7933

Address **Phone**

Suggested Personal Contact: Malcolm O. Perkins

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: Local office, Department of Welfare

B. Provider Eligibility: Providers certified by the state Departments of Health, Medical Assistance Program. Provider agreement between the state and all providers required.

Services Covered:

Physician: Provided

Psychiatrist: Provided. Limited to 50 hours per patient. May be extended with prior authorization.

Psychologist: Provided only if under supervision of a physician and billed by the physician or certified Community Mental Health Clinic.

C. Facility Eligibility:

Services Covered:

Hospital: Provided. Limited to 14 days. Extensions up to 7 additional days require prior approval.

Clinic: Provided, but limited to local health departments and participating hospitals.

Methadone: Provided. Limited to inpatient hospital use, except for one clinic at the Medical College of Virginia.

D. Payment Information: Processed and paid by the Computer Company as a fiscal intermediary.

E. Remarks: Outpatient drug abuse treatment programs must be physician directed and under the auspices of a local health department or through contractual agreement with a Community Health Center. Inpatient treatment is covered at licensed general hospitals.

STATE Washington

Responsible State Agency: Office of Personal Health Services; Department of Social & Health Services

Mail Stop 10-1, Olympia, Washington 98504 (206) 753-5839
Address **Phone**

Suggested Personal Contact: Dr. Robert Hall; Dr. Muriel Taylor (206) 753-5414

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: Local Economic and Social Services Office

B. Provider Eligibility: Providers certified by State Department of Social and Health Services. Prior authorization required for drugs not on the state formula. Written agreement between state and individual providers required.

Services Covered:

Physician: Provided. Limited to two visits per month for new cases and one call per month for old or chronic cases. Additional visits must be justified.

Psychiatrist: Provided. Same basis as physician.

Psychologist: Not provided

C. Facility Eligibility:

Services Covered:

Hospital: Provided. Prior authorization by local medical consultant required for nonemergency conditions.

Clinic: Provided

Methadone: Provided. Either by contract with drug treatment agency that qualifies as a Community Mental Health Center or by a sub-contract between that agency and a methadone maintenance program.

D. Payment Information: Processed and paid by State Department of Social and Health Services.

E. Remarks: Outpatient drug abuse treatment program must meet the criteria established for free-standing clinics or have a valid contractual agreement with a Community Mental Health Center. Services covered include intake-diagnosis, individual and group counseling, day treatment, activities therapy, and medication evaluation.

STATE West Virginia

Responsible State Agency: Department of Welfare, Division of Medical Care

1900 Washington Street, Charleston, West Virginia 25305 (304) 348-8990
Address **Phone**

Suggested Personal Contact: Mr. Eppling

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: Local offices of the Department of Welfare

B. Provider Eligibility: State Division of Medical Care certifies provider eligibility. Invoice form (DWM-12) serves as agreement between the state and providers.

Services Covered:

Physician: Provided

Psychiatrist: Provided

Psychologist: Provided. Both for diagnostic and therapeutic services.

C. Facility Eligibility: Purchase of Services Agreement required between the state and facilities.

Services Covered:

Hospital: Provided. Limits are illness specific.

Clinic: Provided. Must be certified as Medicaid provider.

Methadone: Provided, if prescribed by individual physician and with prior approval.

D. Payment Information: Processed and paid by Blue Cross and Blue Shield of West Virginia.

E. Remarks: Methadone is provided through the State Health Department in clinic settings.

STATE Wisconsin

Responsible State Agency: Department of Health and Social Services

Room 663, 1 West Wilson Street, Madison, Wisconsin 53702 (608) 266-2522
Address **Phone**

Suggested Personal Contact: John Murphy

A. Client Eligibility: Categorically Needy
Medically Needy

Certified by: County Welfare Department and Social Security Administration

B. Provider Eligibility: Blue Cross and Blue Shield certify providers according to criteria formulated by the State Department of Health and Social Services. Application serves as legal agreement.

Services Covered:

Physician: Provided

Psychiatrist: Provided

Psychologist: Provided. Must have referral from a physician and be licensed by the state.

C. Facility Eligibility: Division of Health certifies eligibility of facilities. Blue Cross and Blue Shield issue provider number.

Services Covered:

Hospital: Provided

Clinic: Provided

Methadone: Provided

D. Payment Information: Processed and paid by Blue Cross and Blue Shield of Wisconsin.

E. Remarks: Outpatient drug abuse programs in Wisconsin would have to be incorprated with or have a working agreement with a Community Mental Health Program in order to meet licensing requirements of the Division of Mental Hygiene. The Drug Abuse program's services could then be billed through the C.M.H.P. and be reimbursed by Medicaid. Inpatient drug abuse programs would have to meet licensing requirements for specialty hospitals. Such programs exist for alcoholics but at present there are no drug abuse hospitals in the state.

STATE Wyoming

Responsible State Agency: Department of Health and Social Services, Medical Assistance Services

Hathaway Building, Cheyenne, Wyoming 82802 (307) 777-7533 or 534
Address **Phone**

Suggested Personal Contact: Mrs. Diantha Pearmain

A. Client Eligibility: Categorically Needy

Certified by: County Division of Public Assistance and Social Services and Supplemental Security Program

B. Provider Eligibility: Prior authorization required for out-of-state care. Claim form serves as formal agreement between the state and individual practitioners.

Services Covered:

Physician: Provided

Psychiatrist: Provided

Psychologist: Not provided

C. Facility Eligibility: Agreements are required between the state and facilities.

Services Covered:

Hospital: Provided. Out-of-state care limited to 14 days per spell of illness.

Clinic: Not provided. None in the state.

Methadone: Provided, if given during hospitalization or by a physician in his office. The drug itself would not be covered since the state has no drug program.

D. Payment Information: Processed and paid by the Medical Assistance Services. Drugs are paid for by the counties according to their ability.

E. Remarks: There is no method at the present time for reimbursement of drug treatment programs. The only method for reimbursing drug abuse treatment is through the local Mental Health Centers who can requires Medicaid cooperation in paying for psychiatric services.

APPENDIX C

STATE TITLE XX CHARTS

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STATE TITLE XX CHARTS

This appendix provides state-specific information relating to client, provider, and service eligibility criteria for Medicaid. Additionally, the name, address, and telephone number of the appropriate state authority and an individual to be contacted for further information are listed.

This information was obtained in March 1976 through direct contacts with the various state authorities and was verified for accuracy at that time. However, as state Medicaid policies are subject to change, specific items should be verified prior to initiating actions solely on the basis of this material. Additionally, the voluminous nature of each state's Medicaid regulations has necessitated a highly abbreviated, and therefore incomplete, presentation.

The primary purpose of presenting this information is to help you make a preliminary determination of the potential relevance of your state's Medicaid program as a third party payer. To do this, you should relate the accompanying information to the characteristics of your program and its client population. If it appears worthwhile to pursue Medicaid as a reimburser, you should contact the state authority to obtain more specific information regarding coverage, eligibility, and the procedure for becoming certified as a provider.

ALABAMA

Agency: Alabama Department of Pensions and Security
Address: 64 N. Union Street, Montgomery, Alabama 36130
Phone: (205) 832-6446
Contact Person: Ms. Gethryn Giles

A. Does CASP specifically cover services to drug addicts? Yes ____ No X

The residential services provided are specifically for alcoholics, not drug addicts.

B. Type of services covered:

Diagnostic

Community Mental Health (Counseling)

Psychotherapy

Legal Services

Transportation

Protective Services for Adults

Day Treatment (primarily for the mentally ill, but addicts can receive)

Residential Care

C. Client Eligibility:

AFDC, SSI, and those whose income is 80% or less than state median. No fee scale.

D. Provider Eligibility:

Approximately half of the services are provided by the state and half contracted. Providers are certified by the Department of Pensions and Security. Contractors must provide 25% local matching. All services are specified in the state plan and a needs assessment is conducted each year.

E. Are services available statewide? Yes ____ No ____

ALASKA

Agency: Alaska Department of Health & Social Services
Division of Social Services

Address: Pouch H, Juneau, Alaska 99811

Phone: (907) 465-3170

Contact Person: Ms. Borchick

A. Does CASPP specifically cover services to drug addicts? Yes ____ No X

B. Type of services covered:

Counseling & case management

Day care

Homemaker

Information & referral

Supportive services for children

C. Client Eligibility:

AFDC, SSI, and recipients of State Supplemental Payments, and those whose income is 80% or less than state median. There is no fee scale.

D. Provider Eligibility:

The state is the primary provider; only day care services are contracted.

E. Are services available statewide? Yes ____ No ____

Arizona

Agency: Arizona Social Services Bureau, Department of Economic Security
Address: P. O. Box 6123, Phoenix, Arizona 85007
Phone: (602)271-3511
Contact Person: Bernd Schwartz

A. **Does CASPP specifically cover services to drug addicts?** Yes ____ No x

Proposed plan to cover addicts to be effective October 1, 1976.

B. **Type of services covered:**

Adoption
Adult Protection Services
Child Protection Services
Day Care
Educational
Family Planning
Foster Care
Health-related Services
Home Management
Housekeeper

Information and Referral
Legal Aid and Defense
Nutritional Supplementation
Social Development
Social Problem Solving
Transportation
Residential Treatment for Dependent and Delinquent Children
Special services provided for:

- delinquents
- predelinquents
- developmentally disabled
- mentally disabled
- physically disabled
- substance abusers

C. **Client Eligibility:**

Services provided and eligibility criteria vary according to locality. Financial eligibility is generally to those below 60% to 80% of mean income.

D. **Provider Eligibility:**

E. **Are services available statewide?** Yes ____ No ____

Depends on locality

ARKANSAS

Agency: Arkansas Social Services
Address: 7th & Gaines, P. O. Box 1435, Little Rock, Arkansas 72203
Phone: (501) 371-2071
Contact Person: Ms. Patterson

A. Does CASPP specifically cover services to drug addicts? Yes ___ No X

B. Type of services covered:

Psychotherapy

Halfway Houses

Supportive Services

Vocational Rehabilitation

Mental Health Services

Employment & Training Services

C. Client Eligibility:

AFDC, SSI, and those whose income is 80% or less than state median income. There is no fee scale.

D. Provider Eligibility:

The Drug Abuse Authority has certification power under the Social & Rehabilitative Services Office on Drug Abuse Prevention.

E. Are services available statewide? Yes X No ___

CALIFORNIA

Agency: State Department of Health, Social Services Branch

Address: 714 P Street, Sacramento, California 95814

Phone: (916) 415-7653

Contact Person: Mr. Clark

A. Does CASPP specifically cover services to drug addicts? Yes x No ___

B. Type of services covered:

The addict is viewed as a disabled individual and receives services as any other disabled person would. Types of services offered are:

- Chemotherapy and Psychotherapy inpatient and outpatient services (however, methadone is paid for outside of title XX)
- Family services (family planning services are contracted out)
- All ancillary and social services (i.e., employment, child care, etc.)

C. Client Eligibility:

AFDC , SSI and those whose income is 80% or less than state median. There is no fee scale.

D. Provider Eligibility:

The program is state supervised (State Department of Health) but county administered.

E. Are services available statewide? Yes ___ No ___

Services to disabled individuals are not available statewide. However, other statewide social services are available to addicts, but do not specify this as a target group.

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COLORADO

Agency: Colorado Division of Social Services

Address: 1575 Sherman Street, Denver, Colorado 80203

Phone: (303) 892-2521

Contact Person: Mr. David Ashmore

A. Does CASPP specifically cover services to drug addicts? Yes ____ No X

B. Type of services covered:

Counseling Services

Health Related Services

Individual & Family Adjustment

Legal Services

Information and Referral Services

Transportation

Education & Training

C. Client Eligibility:

AFDC, SSI, and those whose income is below 80% of state median for most services.

D. Provider Eligibility:

County Departments of Social Services in each county are primary provider of services.

Community centered boards provide services to the developmentally disabled.

E. Are services available statewide? Yes X No ____

...although some resources are not available in rural areas. Most drug addiction services provided by county departments are on a referral basis to other agencies.

CONNECTICUT

Agency: Department of Social Services
Address: 110 Bartholomew, Hartford, Connecticut 06115
Phone: (203) 566-2552
Contact Person: Lawrence Marostica

A. Does CASPP specifically cover services to drug addicts? Yes X No ____

B. Type of services covered:

Institutional (public and private)

Community Care and Basic Services

C. Client Eligibility:

AFDC, SSI, and those whose income is not greater than 115% of state median. Client fees are based on ability to pay.

D. Provider Eligibility:

Services are provided by the state and by contractors licensed by the state.

E. Are services available statewide? Yes X No ____

DELAWARE

Agency: Department of Health & Social Services

Address: P. O. Box 309, Wilmington, Delaware

Phone: (302) 571-3174

Contact Person: Dan Cantera

A. **Does CASPP specifically cover services to drug addicts?** Yes ____ No X

B. **Type of services covered:**

There are 18 basic services covered other than WIN Services and Transportation Services. Those most relevant to addicts are Health Related Services and Information and Referral Services.

C. **Client Eligibility:**

AFDC and SSI clients are each eligible for specified services. Other services are available to those with incomes below 80% of the state median.

D. **Provider Eligibility:**

State purchases services from private, nonprofit, and public agencies.

E. **Are services available statewide?** Yes ____ No X

DISTRICT OF COLUMBIA

Agency: Department of Human Resources
Office of Planning and State Agency Affairs

Address: 614 H Street, N.W., Room 703, Washington, D.C. 20001

Phone: (202)629-4955

Contact Person:

A. Does CASPP specifically cover services to drug addicts? Yes ____ No X

There are no services under title XX that are specifically designed for drug addicts but all drug addicts who meet the eligibility factors listed under "C" below are entitled to receive any services listed under "B".

B. Type of services covered:

1. Adoption Services
2. Chore Services
3. Crisis Services
4. Day Care Services
5. Delinquency Prevention and Youth Development Services
6. Family Planning Services
7. Health Related Services
8. Homemaker Services
9. Information & Referral Services
10. Problem Assessment & Resolution
11. Protective Services for Adults
12. Protective Services for Children
13. Substitute Care Services for Adults
14. Substitute Care Services for Children

C. Client Eligibility:

AFDC, SSI, and those whose incomes are below 50% of the median income for a family of four are eligible for all services. Those whose income is not more than 80% of the median income are eligible for services numbers 1, 3, 7, 9, and 14. Persons in need of protection are eligible for services numbers 1, 2, 3, 7, 8, 9, 11, 12, 13, and 14. There is no eligibility requirement for service number 9.

D. Provider Eligibility:

Proposals from interested providers would be reviewed and ranked among other proposed services based upon their merit, since no funds are available for additional services.

E. Are services available statewide? Yes X No ____

FLORIDA

Agency: Health and Rehabilitative Services, Mental Health Program Office/ Drug Abuse Program

Address: 1323 Winewood Boulevard, Tallahassee, Florida 32301

Phone: (904) 488-6169

Contact Person: Dick Warfel

A. **Does CASPP specifically cover services to drug addicts?** Yes ____ No X

The drug program is a part of the Mental Health Program. The target groups consist of those individuals who have mental, emotional, drug or alcohol problems.

B. **Type of services covered:**

Counseling

Employment Services

Health Education Services

Health Related Services

Information & Referral Services

Educational Services

C. **Client Eligibility:**

AFDC, SSI, and those whose income is not greater than 67% of the state median.

D. **Provider Eligibility:**

Drug programs must be licensed by Health & Rehabilitative Services.

E. **Are services available statewide?** Yes X No ____

GEORGIA

Agency: Commissioner's Office, Department of Human Resources
Address: Room 414, State Office Building, Atlanta, Georgia
Phone: (404) 656-4460
Contact Person: Claud Corry

A. Does CASPP specifically cover services to drug addicts? Yes X No ____

B. Type of services covered:

Health Related Services (all services to addicts are included within this area)

Room and board for addicts when participating in a residential treatment program.

C. Client Eligibility:

AFDC, SSI, those with family incomes under $8,365 (family of four) and recipients of protective services.

D. Provider Eligibility:

Providers are certified by the Division of Mental Health.

E. Are services available statewide? Yes ____ No X

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HAWAII

Agency: Department of Social Services and Housing

Address: P. O. Box 339; Honolulu, Hawaii 96309

Phone: (808) 548-5902

Contact Person: Wayne Omuro

A. Does CASPP specifically cover services to drug addicts? Yes X No ____

B. Type of services covered:

Assessment and determination of service needs

Outreach

Individual, educational, and group counseling

Family counseling

Detoxification, milieu, and recreational therapies

Vocational preparation and employment assistance

Transportation

Referral and follow-up supportive services for post-residential treatment

C. Client Eligibility:

AFDC, SSI, And those with incomes below 60% of state median. There is no fee scale.

D. Provider Eligibility:

The Department of Social Services and Housing contracts for services from some providers.

E. Are services available statewide? Yes ____ No X

IDAHO

Agency: Department of Health and Welfare
Bureau of Substance Abuse

Address: Room 327, LBJ Building, Boise, Idaho 83720

Phone: (208) 384-3920

Contact Person: Mr. Adams

A. **Does CASPP specifically cover services to drug addicts?** Yes ___ No X

B. **Type of services covered:**

Not applicable to addicts

C. **Client Eligibility:**

Title XX eligibility does not apply to substance abuse since it is not part of the State Plan.

D. **Provider Eligibility:**

None

E. **Are services available statewide?** Yes ___ No ___

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ILLINOIS

Agency: Illinois Department of Public Aid
Address: 624 South Michigan, Chicago, Illinois 60605
Phone: (312) 341-4565
Contact Person: Ms. Margaret J. Washnitzer, Chief, Bureau of Social Services

A. Does CASPP specifically cover services to drug addicts? Yes X No ____

B. Type of services covered:

Outpatient Services

Counseling and Psythotherapy

Diagnostic Procedures

Chemotherapy (methadone is covered)

Services for Pregnant Addicts

Residential Treatment

Day Training for Special Needs

C. Client Eligibility:

AFDC, SSI, and those whose income is 80% or less than state median. No fees are assessed for outpatient drug abuse services.

D. Provider Eligibility:

As the single state agency, the Department of Public Aid (DPA) contracts with other state agencies to provide the services; the state agencies, in turn, may contract with other service providers. In all cases, client eligibility for services is determined by DPA.

E. Are services available statewide? Yes X No ____

INDIANA

Agency: Indiana Department of Public Welfare, Division of Social Services

Address: 141 S. Meridian, Indianapolis, Indiana 46204

Phone: (817) 633-7667

Contact Person: Don Blinzingr

A. **Does CASP specifically cover services to drug addicts?** Yes X No ____

Services are oriented more toward alcoholics than drug addicts. The majority of these have been designated for exclusive delivery by the Department of Mental Health.

B. **Type of services covered:**

Detoxification

General Counseling

Drug and Alcohol Education, Information, and Referral (not delivered exclusively by Department of Mental Health)

Information and Referral

C. **Client Eligibility:**

AFDC, SSI, and those whose incomes are 80% or less than state median. There is no fee scale.

D. **Provider Eligibility:**

Providers are certified by the State Department of Mental Health.

E. **Are services available statewide?** Yes ____ No ____

Detoxification services are available statewide. Information and referral services are not statewide (offered through public schools in some areas)

IOWA

Agency: Iowa Department of Social Services, Division of Management & Planning

Address: 507 10th Street, Des Moines, Iowa 50319

Phone: (515) 381-3577

Contact Person: Judy Kemmerer, Sheilia Swanson

A. Does CASPP specifically cover services to drug addicts? Yes X No ____

B. Type of services covered:

Services provided to assist individuals in avoiding or overcoming the debilitating effects of drug dependency. Includes preventive community education and professional nonmedical consultation, outreach, inreach, individual, group and/or family counseling and/or non-psychiatric therapy; physical examination to establish chemically dependent status or condition (one-time per client); assist to identify and secure needed health services and working with individuals, families and health providers to assist in the carrying out of health recommendations; follow-up at stated intervals for a period not to exceed six months. Room and board may be included for six months when integral to the delivery of this service to an individual.

C. Client Eligibility:

AFDC, SSI, and those whose income is 80% or less than state median.
No fees for drug dependency services.

D. Provider Eligibility:

Providers are certified by Iowa Drug Abuse Authority, which is contracted with the state to provide services to addicts through local programs.

E. Are services available statewide? Yes X No ____

Title XX is paying for services only in certain areas but other services are picked up by other agencies.

KANSAS

Agency: Kansas Department of Social & Rehabilitation Services

Address: State Office Building, Topeka, Kansas

Phone: (913) 296-3271

Contact Person: Dr. Robert Harder

A. Does CASPP specifically cover services to drug addicts? Yes X No ____

B. Type of services covered:

Counseling

Inpatient & Outpatient Services

Chemotherapy (methadone)

Remedial Care and all Ancillary Services

C. Client Eligibility:

AFDC, SSI, and those with incomes less than 110% of state median.

D. Provider Eligibility:

Providers must be certified by the Kansas Department of Social and Rehabilitation Services.

E. Are services available statewide? Yes X No ____

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KENTUCKY

Agency: Kentucky Department for Human Resources, Bureau for Social Services
Address: 403 Wapping, Frankfort, Kentucky 40601
Phone: (502) 564-6746
Contact Person: Sheila Winnett

A. Does CASPP specifically cover services to drug addicts? Yes X No ____

B. Type of services covered:

Prevention, treatment, and rehabilitation services necessary to prevent or overcome drug dependency, which may include counseling with the drug abuser and his family individually or in groups; diagnostic evaluations; short-term non-medical withdrawal program; treatment and rehabilitation of youth who ordinarily would be processed through the criminal justice system; drug prevention education; outpatient counseling and adjunct treatment services; methadone counseling program; or medical and remedial care, which includes only medical evaluation and short-term treatment, i.e., chemotherapy, antabuse therapy, physical examinations, psychiatric examinations, and/or appropriate laboratory work-ups, when an integral but subordinate part of the services and not available from the other sources; or residential treatment which may include room and board

C. Client Eligibility:

AFDC, SSI, and those whose income is 80% or less than state median. There is no fee scale.

D. Provider Eligibility:

Contracts to provide drug abuse prevention and treatment services through the comprehensive care centers and their affiliates are negotiated cooperatively through the Bureaus for Social Services and Health Services and are approved through the Office of the Secretary, Department for Human Resources. The Bureau for Health Services is the "lead agency" in this process at the state level.

E. Are services available statewide? Yes ____ No X

Drug Abuse Prevention and Treatment Services are available to Area Development Districts 1, 2, 3, 4, 5, 6, 7, 10, 13, 14, and 15 (CASPP for FY '77).

LOUISIANA

Agency: Louisiana Health and Human Resources Administration

Address: P. O. Box 44065, Baton Rouge, Louisiana 70804

Phone: (504) 389-5571

Contact Person: Rupert Thompson

A. Does CASPP specifically cover services to drug addicts? Yes X No ___

B. Type of services covered:

Mental Health

Medical Supportive Services

Counseling Services

C. Client Eligibility:

AFDC, SSI, and those whose income is below 49% of state median.
No fee scale.

D. Provider Eligibility:

An organization seeking provider status must submit a proposal to the state title XX agency outlining its capability to provide one or more of the covered services. This submission will be reviewed both on its own merit and in comparison with those of other organizations proposing to perform the same service. Both for-profit and non-profit organizations are eligible; however, as of 5/76 all contracts awarded have been to non-profit organizations.

E. Are services available statewide? Yes X No ___

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MAINE

Agency: Maine Department of Human Services
Address: State House, Augusta, Maine 04333
Phone: (207) 289-2971
Contact Person: Mrs. Fulton or Mr. Norton

A. Does CASPP specifically cover services to drug addicts? Yes ___ No X

B. Type of services covered:

All basic services as stated in CASPP.

C. Client Eligibility:

AFDC, SSI, and those whose income is below 80% of state median. There is no fee scale.

D. Provider Eligibility:

Depends on the services; must be licensed by the state agency.

E. Are services available statewide? Yes ___ No X

510

MARYLAND

Agency: Social Services Administration, Department of Employment & Social Services

Address: 1315 St. Paul Street, Baltimore, Maryland 21202

Phone: (301) 383-5615

Contact Person: Mr. Sullivan

A. Does CASPP specifically cover services to drug addicts? Yes X No ___

B. Type of services covered:

Services to rehabilitate drug addicts or drug abusers through medical and psychological evaluation, health related services, educational services, referral for legal services, and counseling (individual and family). Services may be provided in a residential setting but do not include room and board. Includes medical tests (blood samples, urinalysis) and medical treatment, as identified. These services are also available to individuals who are in imminent danger of becoming drug abusers.

C. Client Eligibility:

AFDC, SSI, and those whose income is 80% or less than state median. There is no fee scale; however, it may be included in the CASPP for 1976-77.

D. Provider Eligibility:

Drug abuse treatment programs must meet state and federal regulations, as applicable.

E. Are services available statewide? Yes X No ___

MASSACHUSETTS

Agency: Massachusetts Department of Public Welfare

Address: 600 Washington Street; Boston, Massachusetts 02111

Phone: (617) 727-6028

Contact Person: Robert Cole

A. Does CASPP specifically cover services to drug addicts? Yes X No ____

B. Type of services covered:

Community Residential, Day Activity, Emergency, Family & Individual Life, Education and Counselling, Recreation and Sheltered Workshops, and Information and Referral.

C. Client Eligibility:

AFDC, SSI, and those with incomes below 68.5% of state median. No fee scale.

D. Provider Eligibility:

The designated agencies enter into contracts with private provider agencies to provide social service under the title XX program. This is a competitive process, and private provider agencies must be in compliance with applicable federal requirements (such as FIDCR for Day Care Centers).

E. Are services available statewide? Yes X No ____

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MICHIGAN

Agency: Michigan Department of Social Services, Bureau of Social Services

Address: 300 S. Capitol Avenue, Lansing, Michigan 48926

Phone: (517) 373-2860

Contact Person: Mr. A. John Vielbig

A. **Does CASPP specifically cover services to drug addicts?** Yes ____ No X

B. **Type of services covered:**

Substance Abuse Counseling Services.

C. **Client Eligibility:**

AFDC, SSI, and those with incomes not in excess of $625 for a family of four ($325 for an individual).

D. **Provider Eligibility:**

Data pending

Contact Michigan Department of Social Services.

E. **Are services available statewide?** Yes ____ No X

MINNESOTA

Agency: Minnesota Department of Public Welfare, Division of Social Services

Address: Centennial Building; St. Paul, Minnesota 55155

Phone: (612) 296-2307

Contact Person: Gary Haselhuhn

A. Does CASPP specifically cover services to drug addicts? Yes ___ No X

B. Type of services covered:

Services most relevant to addicts would be:

- Residential Treatment
- Counseling
- Health Related Services (Arranging & Referral)

C. Client Eligibility:

AFDC, SSI, and those with incomes below 115% of state median. Graduated fee scale for individuals having incomes between 60% and 115% of state median.

D. Provider Eligibility:

Providers must be licensed.

E. Are services available statewide? Yes ___ No X

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MISSISSIPPI

Agency: Mississippi State Department of Public Welfare
Address: Box 4321 Tondren Station, Jackson, Mississippi 39216
Phone:
Contact Person:

A. Does CASPP specifically cover services to drug addicts? Yes ____ No X

B. Type of services covered:

Comprehensive Social Treatment Services

Diagnostic & Evaluation Services

Information & Referral

Family & Individual Counseling

Transportation

C. Client Eligibility:

AFDC, SSI, and those whose income is 115% or less than the state median. No fee scale if income below 80% of state median.

D. Provider Eligibility:

There are some services provided directly by the state and some are purchased through the Department of Public Welfare who determines eligibility.

E. Are services available statewide? Yes ____ No ____

MISSOURI

Agency: Missouri Division of Family Services

Address: Broadway Street Office Building, Jefferson City, Missouri 65101

Phone: (314) 751-2563

Contact Person: Mr. Morgan

A. Does CASPP specifically cover services to drug addicts? Yes X No ____

B. Type of services covered:

The one service that is specifically geared to addicts is alcohol and drug abuse counseling.

C. Client Eligibility:

AFDC, SSI, and families and individuals whose income is 80% or less than the state median. There is no fee scale.

D. Provider Eligibility:

State provides services through the Department of Mental Health and also certifies private contractors.

E. Are services available statewide? Yes X No ____

MONTANA

Agency: Montana Department of Social & Rehabilitative Services

Address: P. O. Box 1723, Helena, Montana 59601

Phone: (406) 449-3724

Contact Person: Mr. Raymond Linder

A. Does CASPP specifically cover services to drug addicts? Yes X No ____

B. Type of services covered:

Basic services such as day care, information and referral, counseling.

C. Client Eligibility:

Varies with the services--for specifics, contact the above office.

D. Provider Eligibility:

State provides some services and also contracts for services with local nonprofit agencies. Contractors are certified by the County Social Services Department.

E. Are services available statewide? Yes X No ____

517

NEBRASKA

Agency: Nebraska Division of Social Services

Address: 4900 O Street, Lincoln, Nebraska 68510

Phone: (402) 471-2983

Contact Person: Ms. Mary Jo Iwan

A. Does CASPP specifically cover services to drug addicts? Yes ____ No X

B. Type of services covered:

Services to drug abusers are not provided under title XX in Nebraska.

C. Client Eligibility:

AFDC, SSI, and those with incomes below 42% of state median income for family of four.

D. Provider Eligibility:

E. Are services available statewide? Yes ____ No ____

NEVADA

Agency: Nevada Department of Human Resources

Address: 251 Jennell Drive, Capital Complex; Carson City, Nevada 89701

Phone: (702) 885-4771

Contact Person: Ms. Mary Lee

A. Does CASPP specifically cover services to drug addicts? Yes ___ No X

B. Type of services covered:

Diagnostic, evaluation, counseling, vocational education and training, and job placement.

C. Client Eligibility:

AFDC, SSI, and those whose income is 63% (80% if have Medicaid Card) or less than state median income for a family of four.

D. Provider Eligibility:

Potential provider must submit a proposal identifying the type of service to be offered and demonstrating its capability to effectively perform the service. A proposed budget must be included with the proposal.

E. Are services available statewide? Yes X No ___

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NEW HAMPSHIRE

Agency: State Department of Welfare

Address: 8 Loden Road, Concord, New Hampshire

Phone: (603) 271-1110

Contact Person: Gloria Bedmarczyk

A. Does CASPP specifically cover services to drug addicts? Yes ____ No X

B. Type of services covered:

C. Client Eligibility:

D. Provider Eligibility:

E. Are services available statewide? Yes ____ No ____

NEW JERSEY

Agency: Division of Social Services, Planning Unit

Address: 116 West State Street, Trenton, New Jersey 08608

Phone: (609) 292-1946

Contact Person: Joan Maruhnic

A. Does CASPP specifically cover services to drug addicts? Yes ____ No X

B. Type of services covered:

Services to drug abusers are not provided under title XX in New Jersey.

C. Client Eligibility:

AFDC, SSI, and those with incomes below 80% of state median income for a family of four.

D. Provider Eligibility:

E. Are services available statewide? Yes ____ No ____

521

NEW MEXICO

Agency: New Mexico Division of Social Services

Address: P. O. Box 2348, Santa Fe, New Mexico 87503

Phone: (505) 827-5175

Contact Person: Mr. Ortiz Y. Pino

A. Does CASPP specifically cover services to drug addicts? Yes ___ No X
However, services to addicts (e.g., counseling) are included under the general category of health support services.

B. Type of services covered:

Health support services, day-care services for adults, protective services for adults and information and referral services.

C. Client Eligibility:

AFDC, SSI and those whose income is 48% or less than the state median. There is no fee scale for covered services.

D. Provider Eligibility:

The state contracts with the Department of Hospitals who develops subcontracts and determines criteria for awarding the subcontracts.

E. Are services available statewide? Yes ___ No X

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NEW YORK

Agency: New York State Department of Social Services

Address: 1450 Western Avenue, Albany, New York 12243

Phone: (518) 457-7345

Contact Person: Mr. Fredericks

A. Does CASPP specifically cover services to drug addicts? Yes ____ No X

B. Type of services covered:

Social Adjustment Services

Employment

Note:

There are different mixes of services in each district.

C. Client Eligibility:

AFDC, SSI, and those whose income is below 62% of state median.

D. Provider Eligibility:

Depends on services provided(e.g., counseling--recognized agency or individual qualifications)

E. Are services available statewide? Yes ____ No X

NORTH CAROLINA

Agency: Division of Social Services
Address: 325 North Salisbury Street, Raleigh, North Carolina 27611
Phone: (919) 829-5947
Contact Person: Mrs. Joan Holland

A. Does CASPP specifically cover services to drug addicts? Yes X No ____

B. Type of services covered:

Individual and Group Counseling

Family Counseling

Assistance in Obtaining and Retaining Employment

Legal Advocacy

Short-Term Residential Care

> Includes nonmedical detoxification services and medical or remedial care when integral but subordinate to the regimen of services provided.

C. Client Eligibility:

AFDC, SSI, and those whose incomes are 80% or less than state median (for drug specific services). Income levels for other services vary according to the service area.

D. Provider Eligibility:

Providers are certified by the Division of Social Services.

E. Are services available statewide? Yes ____ No X

All of the services covered are not available in all areas of the state.

NORTH DAKOTA

Agency: North Dakota Social Services Branch, Division of Community Services

Address: 15th Floor, State Capitol Building, Bismark, North Dakota 55501

Phone: (701) 224-2316

Contact Person: Mr. Owen Carson

A. Does CASPP specifically cover services to drug addicts? Yes X No ____

B. Type of services covered:

Counseling Therapy

Advocacy

Health Related Services

Information & Referral

C. Client Eligibility:

AFDC, SSI, and those with incomes below 115% of state median except for certain services not directly related to drug addicts.

D. Provider Eligibility:

Most services are provided directly by the state.

E. Are services available statewide? Yes X No ____

OHIO

Agency: Ohio Department of Public Welfare, Division of Social Services

Address: 30 E. Broad, 30th Floor, Columbus, Ohio 43215

Phone: (614) 446-7884

Contact Person: Mr. Duhigg

A. **Does CASPP specifically cover services to drug addicts?** Yes ____ No X

B. **Type of services covered:**

Codes for drug and other addictions are spelled out in the following areas:

Employment & Training Services (non-WIN)

Developmental Services for Children and Youth

Developmental Socialization Services for Adults

Protective Care fore Adults

Counseling

Health-Related Services

Transportation

Residential Treatment

Day Care for Adults

Emergency Shelter

Mental Health-Mental Retardation Related

C. **Client Eligibility:**

AFDC, SSI, and those whose income is at or below $8,200 for a family of four. Sliding fee scale, based on income.

D. **Provider Eligibility:**

Contractors are jointly approved by the Ohio Department of Mental Health/Retardation and local county welfare departments.

Criteria is based on a joint needs assessment within each geographic area.

E. **Are services available statewide?** Yes X No ____

OKLAHOMA

Agency: Oklahoma Department of Institutions - Social and Rehabilitative

Address: P. O. Box 25352, Oklahoma City, Oklahoma 73125

Phone: (405) 521-3531

Contact Person: Mr. Powell

A. Does CASPP specifically cover services to drug addicts? Yes ____ No X

None specifically for addicts, but certain services can be directed toward drug addicts who are otherwise eligible.

B. Type of services covered:

Improved Individual/Family Life Functioning

Health Related Services

Education

Adult Day Care

Emergency Shelter

Counseling

C. Client Eligibility:

AFDC, SSI, those eligible for Medicaid who do not receive a maintenance assistance payment, and those whose income is at or below 80% of state median.

D. Provider Eligibility:

Variable, depending on the service; however, formal criteria had not been established as of March, 1976.

E. Are services available statewide? Yes X No ____

OREGON

Agency: Oregon Department of Human Resources

Address: Public Service Building; Salem, Oregon 97310

Phone: (503) 378-3154

Contact Person: Mr. Charles Bocci

A. Does CASPP specifically cover services to drug addicts? Yes ____ No X

B. Type of services covered:

Services to drug abusers are not provided under title XX in Oregon.

C. Client Eligibility:

AFDC, SSI, and those with incomes below 115% of state median.

D. Provider Eligibility:

E. Are services available statewide? Yes ____ No ____

PENNSYLVANIA

Agency: Pennsylvania Department of Public Welfare Office of Social Services

Address: Room 322, Health & Welfare Bldg., Harrisburg, Pa. 17120

Phone: (717) 787-7406

Contact Person: Mrs. Wallace

A. **Does CASPP specifically cover services to drug addicts?** Yes ____ No X

B. **Type of services covered:**

Employment

Information & Referral

Transportation

Socialization & Recreation

Counseling

Day Care - Adult and Child

Family Planning

Legal Services

C. **Client Eligibility:**

AFDC, SSI/State Supplementation, and those with monthly income not exceeding the equivalent of $724 for a four-person family.

D. **Provider Eligibility:**

The state has contracted with the Governor's Council on Drug and Alcohol Abuse, which contracts with specific programs.

E. **Are services available statewide?** Yes ____ No ____

RHODE ISLAND

Agency: Department of Social and Rehabilitative Services, Division of Community Services

Address: Amie J. Forand Building, 600 New London Avenue, Cranston, RI 02920

Phone. (401) 464-2121 or 464-2423

Contact Person: John J. Affleck (Director); Anthony E. Ricci (Asst. Director)

A. Does CASPP specifically cover services to drug addicts? Yes ____ No X

B. Type of services covered:

The only covered service potentially relevant to drug addicts is employment assistance, provided by the state.

C. Client Eligibility:

AFDC, SSI, and those with incomes below 50% of the state median.

D. Provider Eligibility:

Services are provided primarily by the state. Mental Health Retardation and Hospital (MHRH) has primary responsibility for drug addicts and alcoholics. Additionally, some services are provided by private agencies/organizations that are funded principally by the Governor's Justice Commission.

E. Are services available statewide? Yes X No ____

SOUTH CAROLINA

Agency: South Carolina Department of Social Services

Address: P.O. Box 1520, Columbia, South Carolina 29202

Phone: (803) 758-7955

Contact Person: Dr. Samuel Griswold

A. **Does CASPP specifically cover services to drug addicts?** Yes X No ____

Special Services for Alcohol and Drug Abusers

B. **Type of services covered:**

Developmental

Education & Training

Employment

Health Support Services

Legal Services

Life Skills Education

Transportation

C. **Client Eligibility:**

AFDC, SSI, and those with incomes below 80% of state median income.

D. **Provider Eligibility:**

Determined by Contracts & Grants Division of Department of Social Services. Providers must be legitimate social service agencies and meet 30% of the cost of services.

E. **Are services available statewide?** Yes X No ____

SOUTH DAKOTA

Agency: South Dakota Department of Social Services; Office of Program Services

Address: State Office Building, Pierre, South Dakota 57501

Phone: (605) 224-3227

Contact Person: Mr. Slattery

A. Does CASP specifically cover services to drug addicts? Yes ____ No X

B. Type of services covered:

Mental health evaluation and treatment.

Emergency hospitalization including room, board, and medical care.

Individual and family counseling.

Transitional residential programming (half-way houses)

C. Client Eligibility:

AFDC, SSI, and those whose income is below 115% of the state median. Sliding fee scale for those with incomes between 60% - 115% of state median.

D. Provider Eligibility:

Services are provided by the state and purchased under contract with Mental Health Centers, and private non-profit social agencies.

E. Are services available statewide? Yes X No ____

TENNESSEE

Agency: Tennessee Department of Human Services, Division of Social Services

Address: 306 State Office Building, Nashville, Tennessee 37219

Phone: (615) 741-2586

Contact Person: Mr. Burkhardt

A. Does CASPP specifically cover services to drug addicts? Yes ____ No X

B. Type of services covered:

Family & Individual Counseling

Residential Treatment

Transportation

Information and Referral

Legal Services

Protective Service for Adults and Children

C. Client Eligibility:

AFDC, SSI, and those whose income is either 70% or 80% (or below) of state median, depending on type of client. Sliding fee scale for those with incomes between 46-80% of state median.

D. Provider Eligibility: No established criteria.

Abstract of service to be provided must be submitted to a regional office (Department of Human Services) for approval, then the Community Service Office will assist in developing a proposal for approval to Division of Social Services.

Residential service is a purchased service; others are both provided by state and purchased.

E. Are services available statewide? Yes ____ No X

The state plan permits all services to be made available statewide, however, all services have not been developed in all areas.

TEXAS

Agency: Texas Department of Public Welfare, Social Services Branch
Address: John H. Regan Building, Austin, Texas 78701
Phone: (512) 475-6481
Contact Person: Kay Love

A. Does CASPP specifically cover services to drug addicts? Yes X No ____

B. Type of services covered: (general)

Crisis Intervention

Halfway House

Sheltered Employment

Socialization

Community Services

C. Client Eligibility:

AFDC, SSI, and those whose incomes are at or below 60% of state median. No fee scale.

D. Provider Eligibility:

Providers are approved through the State Contracts Division of Social Service.

E. Are services available statewide? Yes X No ____

However, not all services are available in all districts.

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UTAH

Agency: Utah Department of Social Services

Address: Suite 303, 243 E. 4th S. Street, Salt Lake City, Utah 84111

Phone: (801) 533-6532

Contact Person: Mr. Bruce Bergen & Mr. Wheeler

A. Does CASPP specifically cover services to drug addicts? Yes X No ___

Drug and Alcohol Counseling Services

B. Type of services covered:

Individual and Family Counseling

Educational Guidance

Employment Guidance and Training

Information and Referral

Legal Services

Protective Service Shelter Care

Transportation

C. Client Eligibility:

Generally, SSI, AFDC, and those whose income is 80% or lower than state median.

D. Provider Eligibility:

Determined by various local planning entities in cooperation with the Department of Social Service. Facility must be state licensed and provide a service that is consistent with the state's comprehensive plan.

E. Are services available statewide? Yes ___ No X

Services are available in most areas.

VERMONT

Agency: Vermont Agency of Human Services, Division of Planning
Address: 83 River Street, Montpelier, Vermont 05602
Phone: (802) 828-3433
Contact Person: Bernard Germain or Allen Ploof

A. Does CASPP specifically cover services to drug addicts? Yes ____ No X

B. Type of services covered:

Services to drug abusers are not provided under title XX in Vermont.

C. Client Eligibility:

AFDC, SSI, and those meeting the particular income level requirement established for a given service.

D. Provider Eligibility:

E. Are services available statewide? Yes ____ No ____

VIRGINIA

Agency: Department of Welfare, Division of Social Services
Address: P. O. Box K-176, Richmond, Virginia 23288
Phone: (804) 786-8986
Contact Person: Mr. Haskett

A. **Does CASPP specifically cover services to drug addicts?** Yes X No ____

Drug counseling and treatment. This service includes problem identification, rehabilitative, social, vocational, and adjustment services. Medical care is included. Room and board is a component when residential care is needed.

B. **Type of services covered:**

Additional covered services that are relevant to drug addicts are:

- Legal Services
- Employment
- Information and Referral

C. **Client Eligibility:**

AFDC, SSI, and those whose income is at or below 70% (50% for some client categories) of state median. There is no fee scale.

D. **Provider Eligibility:**

Generally providers are approved by the Division of Drug Abuse Control and/or must be state licensed.

E. **Are services available statewide?** Yes ____ No X

WASHINGTON

Agency: Washington Department of Social & Health Services

Address: Public Lands Building, Olympia, Washington 98504

Phone: (206) 464-6931

Contact Person: Mr. Lampe

A. Does CASPP specifically cover services to drug addicts? Yes ___ No X

B. Type of services covered:

Services covered under title XX are not directly relevant to drug abusers.

C. Client Eligibility:

AFDC, SSI, and those with incomes below 80% of state median.

D. Provider Eligibility:

E. Are services available statewide? Yes ___ No ___

WEST VIRGINIA

Agency: West Virginia Department of Welfare

Address: 1900 Washington Street, East, Charleston, West Virginia 25305

Phone: (304) 348-7980

Contact Person: R. Larry Beckett, State Director, Purchase of Social Services

A. Does CASP specifically cover services to drug addicts? Yes X No

B. Type of services covered:

Counseling

Residential Care

C. Client Eligibility:

AFDC, SSI, Medicaid and those whose income is less than 80% of the state median.

D. Provider Eligibility:

Depends on nature of contract and service provided. Licensing required for residential care.

E. Are services available statewide? Yes No x

WISCONSIN

Agency: Wisconsin Department of Health & Social Services

Address: 1 W. Wilson Street, Madison, Wisconsin 53702

Phone: (608) 266-2850

Contact Person: Mr. Trewartha

A. Does CASPP specifically cover services to drug addicts? Yes ____ No X

B. Type of services covered:

C. Client Eligibility:

D. Provider Eligibility:

E. Are services available statewide? Yes ____ No ____

WYOMING

Agency: Wyoming Division of Public Assistance and Social Services

Address: Hathaway Building, West Cheyenne, Wyoming 82002

Phone: (307) 777-7561

Contact Person: Mr. Richard Weatherman

A. Does CASPP specifically cover services to drug addicts? Yes ____ No X

However, several are directly relevant to addicts.

B. Type of services covered:

Counseling

Legal Services

Information & Referral

Socialization Services

Transportation Service

Mental Health Centers

C. Client Eligibility:

AFDC, SSI, Medicaid and those whose income is not more than 45% of state median. No fee scale.

D. Provider Eligibility:

No established criteria; if state cannot provide service, a provider is selected through a bid and selection process.

E. Are services available statewide? Yes X No ____

APPENDIX D

ADDITIONAL REFERENCES AND RESOURCES

ADDITIONAL REFERENCES AND RESOURCES

Third-Party Reimbursement. Report Series 35 Issue C. A series of documents dealing with various topics related to third-party payments, available free of charge from:

National Clearinghouse for Drug Abuse Information
P. O. Box 1635
Rockville, MD 20850

Regulations and Guidelines for Health Services Funding. Available free of charge from:

National Clearinghouse for Drug Abuse Information
P. O. Box 1635
Rockville, MD 20850

Confidentiality of Alcohol and Drug Abuse Patient Records, General Provisions. Federal Register, July 1, 1975, beginning on page 27802.

Title XX Regulations. Federal Register, June 27, 1975, page 27352.

All additions or corrections to regulations and newly published regulations are presented in the Federal Register. It is available at $.15 per page or $.75 for a complete issue from:

National Archives Building
Office of the Federal Register
8th Street and Pennsylvania Avenue, N.W.
Washington, D.C. 20408

A Citizen's Handbook: Social Services '75. Reference SRS 75-23038. This document provides a quick and easy reference to title XX and may be obtained without charge from:

Community Services Administration
Social and Rehabilitation Service
Department of Health, Education, and Welfare
330 C Street, S.W.
Washington, D.C. 20201

The Social Security Act (As Amended Through January 4, 1975) and Related Laws. Reference Number Y4.F49:S01/39, $5.80, available from:

Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402

1974 Social Security and Medicare Explained--Including Medicaid. This document provides a general, easy to understand explanation of the Medicare and Medicaid programs and is available for $5.00 from:

The Commerce Clearinghouse, Inc.
4025 W. Peterson Avenue
Chicago, IL 60646

Standards for Drug Abuse Treatment and Rehabilitation Programs. Available for $7.50 from:

Joint Commission on Accreditation of Hospitals
875 North Michigan Avenue
Chicago, IL 60611

Confidentiality of Alcohol and Drug Abuse Patient Records - A Self-Paced Programmed Instructional Course. Available for $5.50 from:

National Drug Abuse Center
1901 North Moore Street
Arlington, VA 22209

Private Third Party Reimbursement. Topics in Health Care Financing, 2(1). Available from Aspen Systems Corporation, 20010 Century Boulevard, Germantown, MD 20767. Price: $9.75 to subscribers to Topics in Health Care Financing (subscription rate: $29.75 per year - four issues). This document is not available to non-subscribers.